Consent Form

Patient Name: _____ Date: _____

Sign your initials next to each paragraph. Full signature required on page 2.

_____ **Notice regarding electronic signature.** The following are available and can be signed in paper form. Anyone signing this document can later choose to sign the paper form without fees or penalties. The electronic signatures will apply to all present and future transactions between signer and Darien Integrative Medicine. Our staff will be happy to provide hardware and software needed to read, save, and copy this document in its entirety.

_____ **Consent for treatment.** I agree and consent to examination and treatment by Dr. Michael E Doyle, MD and the staff of Darien Integrative Medicine. I also agree and consent to the use of my records and medical information for the purpose of discussing, improving and coordinating my health care with other healthcare providers. I understand that:

_____ Dr. Doyle does not provide the full range of primary care services and does not routinely provide ”on call” or emergency care. I understand that these necessary services should be accessed through another physician or through the 911 system;

_____ Dr. Doyle will recommend treatments that he believes are most appropriate for my condition. Some of these treatments may be considered “alternative”, experimental or outside the medical mainstream;

_____ My initial evaluation involves a comprehensive health questionnaire, a physical examination and recommendations for testing. As a rule, the first visit does not include major treatment recommendations**.** I am fully aware that **test results will be discussed during scheduled appointments,** except under special circumstances;

_____ **The use of certain hormones including estrogen, progesterone, testosterone and** DHEA may require annual cancer screening. Some of these exams are not provided by Dr. Doyle. I am solely responsible for obtaining these exams when needed - through qualified physicians;

_____ **Dr. Doyle requires regular office visits** to ensure safe and effective care**. Dr. Doyle will not be able to refill my prescriptions unless necessary follow-up visits have occurred.** In cases where Dr. Doyle is unable to continue refilling my prescriptions, **I may see a local doctor or urgent care physician or other in order to examine me and refill options until I am able to follow with Dr. Doyle**.

_____ **Waiver for treatment during pregnancy**. I understand that there may be risks to me and my fetus from the use of prescription and nonprescription treatments and that some treatments that Dr. Doyle prescribes may not be approved for use in pregnancy. I understand that if I am, or could become pregnant, I will discuss the safety of all treatments with a qualified obstetrician prior to their use. I also understand that cortisol (hydrocortisone), DHEA, progesterone, and thyroid hormones that are used at doses that may suppress TSH levels are some of those treatments that are of uncertain safety during pregnancy.
I understand that there are risks associated with any treatment that I choose and that I have the right to refuse treatment or seek medical attention elsewhere at any time.

_____ **Consent to receive medical and nonmedical information through email.** I consent to receive medical and nonmedical information through email and/or patient portal. It is my responsibility to notify the office of any changes to my email or patient portal account.

_____ **Billing policy**. I understand and agree to the following:
Dr. Doyle is an out-of-network provider and that I am required to pay the amount due for any service to Darien Integrative Medicine at the time of service by Cash, check, debit or credit card. I will be provided an insurance claim form that I may submit to my insurance provider for out-of-network reimbursement. **I cannot and will not submit for reimbursement through Medicare.**

_____ Telephone appointments are available but may not be reimbursed by insurance. I understand that extended visits may be needed for complex cases or out-of-town patient's and that all scheduled times are approximate and include time spent reviewing records, reports and/or consulting with other healthcare professionals.

_____ A nonrefundable $350 fee will be charged to my debit or credit card upon scheduling a new patient evaluation. This fee will be applied toward the fee for my initial evaluation.
I understand and authorize that Darien Integrative Medicine will keep my debit/credit card information securely on file and charge this card for services rendered, products, supplies and/or fees such as late cancellation, "no show", rescheduling and/or record fees.
Per Connecticut law, I may be charged up to $0.65 per page for copies of my medical records.
In the event of a return check will be charged $35.

_____ **Fee schedule.** I agree that a cancellation fee of $150 will apply if I fail to cancel my follow-up appointment at least one full business day prior to my appointment or 2 business days prior to a Monday follow-up appointment. A cancellation fee of $350 will apply if I fail to cancel my new patient evaluation appointment more than 2 business days prior to my scheduled appointment.
After-hours and special Friday appointments will be charged using weekend rates. Follow-up rates applied to both in person and telephone consultations.

Focused Follow-up Visit---up to 25 minutes: $285. (Saturday: $350)
Complete Follow-up Visit---up to 45 minutes: $475 (Saturday: $550)
Extended Follow-up Visit---up to 60 minutes: $650 (Saturday: $750)

Focused New Patient Evaluation---up to 60 minutes: $675 (Saturday: $790)
Complete New Patient Evaluation---up to 90 minutes: $950 (Saturday: $1090)

**These prices are subject to change without prior notification.

I certify that I have read, understand and consent to all of the above.

Patient Signature _____ Date _____

Printed Name _____ Date _____