CONSENT FORM	***Initials***
I understand that telephone appointments are available but may not be reimbursed by Medicare or private insurers.	↪
CONSENT for TREATMENT. *I agree and consent to examination and treatment by Michael E. Doyle, MD and Stamford Integrative Medicine's staff. 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 health care 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 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;* *Initial evaluation involves a review of comprehensive health questionnaire, a physical examination and recommendations for testing. The first visit does not include major treatment recommendations.* ***I am fully aware that test results will be discussed during scheduled appointments unless otherwise indicated;*** *The use of certain hormones includes estrogen, progesterone, testosterone, and DHEA requires annual cancer screening. Dr. Doyle may not provide these necessary exams. I am solely responsible for obtaining these examinations from qualified physicians. Dr. Doyle requires regular office visits to ensure safe and effective care and that he may not be able to refill prescriptions unless a follow-up visits occur as required.*	↪
WAIVER FOR TREATMENT DURING PREGNANCY. *I understand that there may be risks to me and my fetus from the use of prescription and non-prescription 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 an obstetrician (OB) prior to their use. I also understand that cortisol (hydrocortisone), DHEA, progesterone, and thyroid hormones given at doses that may suppress TSH levels are some of the treatments of uncertain safety during pregnancy.* ***There are risks associated with any treatment that I choose and that I have the right to refuse treatment at any time.***	↪
EMAILS AND PATIENT IDENTIFICATION. *I consent to receive medical and non-medical 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. I understand that my patient portal account will be created free of charge after my initial consultation. I agree to use of my image for medical records only. I will provide my license, government issued ID or have my picture taken on my appointment time. I also allow Stamford Integrative Medicine to use publicly available image of me to be a part of my medical records. Publicly available image means the use of internet or the social media.*	↪
BILLING POLICY. *I understand and agree that Dr. Doyle is an out of network provider and that I am required to pay the amount due at the time of service either 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 to Medicare. I understand that Dr. Doyle has opted out of Medicare.I understand that extended visits may be needed for out-of-town patients and complex cases and that all scheduled times are approximate and include time spent reviewing records, reports and/or consulting with other professionals. A non-refundable fee of fifty dollars will be charged to the debit or credit card upon scheduling a new patient evaluation. This fee will be applied toward the new patient's evaluation appointment fee. I understand and authorize Stamford Integrative Medicine to keep my debit /credit card on file AND charge this card for services rendered, products, and supplies and/or for fees such as late cancellation, no show, rescheduling, and/or record fees.* *Per Connecticut law, I may be charged up to sixty five cents per page for copies of my medical records. In the event of returned check, I will be charged thirty five dollars.*	. ↪
Fee Schedule. *I agree that a cancellation fee of one-hundred twenty-five dollars will apply if I fail to cancel my follow-up appointment one full business day prior to appointment or two business days for a Monday follow-up appointment.* *The cancellation fee of two-hundred twenty five dollars will apply if I fail to cancel my new patient evaluation appointment two*	↪

business days prior to appointment. After hours and Friday appointments will be charged using weekend rates. Follow-up appointment rates apply to both in-person and telephone consultations.	
New Patient Evaluation up to 90 mins (weekend) $980 *New Patient Evaluation up to 60 mins (weekend) $650* *New Patient Evaluation up to 90 mins (weekdays) $850* ***New Patient Evaluation up to 60 mins (weekdays) $590*** *Follow-up appointment up to 60 mins(weekdays) $590* *Follow-up appointment up to 45 mins(weekdays) $375* ***Follow-up appointment up to 25 mins(weekdays) $225*** *Follow-up appointment up to 60 mins(weekend) $650* *Follow-up appointment up to 45 mins(weekend) $400* *Follow-up appointment up to 25 mins(weekend) $250*	
NOTICE REGARDING ELECTRONIC SIGNATURE. *The following are available in 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 the signer and Stamford Integrative Medicine. Our staff will be happy to provide hardware and software requirements to read, save, and copy this document in its entirety.*	

Updated as of 06/20/2016

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

Name	
Date of Birth	
Street Address (Street, City, State, Zip)	
Sign & Date	

Private Contract / Medicare Opt-Out Form

This agreement is between Michael, E Doyle, M.D., whose principal place of business is 6 THORNDAL CIR DARIEN CT 06820 and

Beneficiary:	*Who resides at :*
Medicare ID Number:	

and who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his/her legal representative that Physician has opted out of the Medicare program effective on 07/01/2013 for a period of at least two years is not excluded from participating in Medicare Part B under [1128] 1128, [1156] 1156, or [1892] 1892 or any other section of the Social Security Act. Physician agrees to provide the following medical services to the beneficiary (the "Services"); medical and physician services, health counseling, diagnostic testing and ancillary health services. In exchange, for the Services, the beneficiary agrees to make payment to the physician pursuant to the attached fee schedule.

Beneficiary or his/her legal representative agrees, understands and expressly acknowledges the following:

X_____ Beneficiary or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

X_____ Beneficiary or his/her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

X_____ Beneficiary or his/her legal representative agrees not to submit a claim to Medicare or to ask the physician to submit a claim to Medicare, even if covered by Medicare Part B.

X_____ Beneficiary or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

X_____ Beneficiary or his/her legal representative enters into this contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

X_____ Beneficiary or his/her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

X_____ Beneficiary or his/her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

X_____ Beneficiary or his/her legal representative acknowledges that a copy of this contract has been made available to him.

Executed on: (date)	
Beneficiary or his/her legal representative:	*And Dr. Michael E. Doyle* ***Michael E. Doyle*** *(Electronically Signed)*