

# Health Partners LLC

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## Financial Responsibility

I accept full responsibility for payment of all fees for products and services provided to myself and/or my dependent by Health Partners LLC. I understand that Health Partners LLC does not accept insurance or Medicare and agree to pay all charges associated with products and services provided by Health Partners LLC with no expectation of insurance reimbursement. I understand that Health Partners LLC will provide a receipt for services that I may choose to file with my health insurance company, but I also understand that filing this receipt with my insurance company in no way guarantees reimbursement and that Health Partners LLC is not responsible for obtaining reimbursement from my insurance company on my behalf. I further agree to pay all charges (such as collection agency, commissions, attorney fees, court costs, returned check costs) incurred by Health Partners LLC in the pursuit of payment for my delinquent account in addition to the full balance of my account. I also understand that interest charges of 18% per annum (calculated monthly) may accrue on delinquent account balances and agree to pay such charges if my account becomes delinquent.

Many potential patients desire to speak to our Providers prior to making their first new patient appointment. Health Partners LLC values communication with potential patients, and welcomes phone consults to determine if our practice is a good fit for both Provider and patient. Health Partners LLC offers a 30-minute phone consult for \$90. This non-refundable fee must be paid in advance of the phone consult.

Health Partners LLC collects a set-up charge prior to scheduling new patients. This set-up charge ensures that the patient is entered in the electronic medical record system, patients are sent necessary questionnaires for their appointment, and completed questionnaires are reviewed before the patient comes in for their appointment. The set-up fee also ensures that necessary records are requested by Health Partners LLC prior to the appointment, and once received, are reviewed before the initial appointment (if received before the appointment). Please note additional charges will apply for records in excess of 20 pages total that are faxed to our office or require copying by our staff. See section "Fax/Copy Policy."

I understand all the above statements and that I am responsible for paying a set-up fee of \$100.00 when scheduling my appointment. This set-up fee is non-refundable, and is a separate charge from my appointment cost.

- Please initial: \_\_\_\_\_

### **Cancellation Policy**

Health Partners LLC understands that emergencies come up that may make rescheduling your appointment necessary. In the event you need to cancel your appointment, please call our office with 48 hours notice. Appointments canceled within 48 business hours of scheduled appointment are subjected to a cancellation fee of \$75 at the discretion of Health Partners LLC.

### **Appointment Time and Cost**

Standard new patient appointments are priced to include up to 1.5 hour for \$395 (includes \$100 non-refundable set up charge due at scheduling.)

Complex new patient appointments are up to up to 1.5 hour for \$495 (includes \$100 non-refundable set up charge due at scheduling.)

Time that lapses over 1.5 hour is charged in 15 minute increments of \$45 each increment.

Follow up appointments are priced by time at our regular rate of \$90 per 30 minutes, and \$45 for each additional 15 minute increment thereafter.

We value communication with our patients and allow for all appointments a maximum of 2 hours. Appointment length must be managed by the patient. Patients who desire to keep appointments to a certain length of time are urged to set an alarm and let their Provider know when they need the appointment to come to an end.

- Please initial: \_\_\_\_\_

***New Patient appointment:*** Due to the large amount of time blocked for a new patient appointment, one cancellation with rescheduling is permitted. If cancellation with rescheduling recurs, an appointment deposit of the full appointment cost may be due before re-scheduling, and will not be refunded in the event of a no-show or cancellation thereafter.

***Follow up appointments:*** Cancellations with rescheduling that occur on a chronic basis may be subject to an appointment deposit to hold appointment. The deposit will be applied the cost of the appointment. If appointment is canceled within 48 business hours before the appointment time the deposit is refundable. Appointments canceled within 48 hours of the scheduled appointment time will not be refunded.

***All decisions to charge or refund for appointment deposits are left at the discretion of the Provider.***

- Please initial: \_\_\_\_\_

I understand that I may be charged a late fee of \$75 if my appointments are not canceled or rescheduled at least forty-eight (48) hours prior to my scheduled appointment time.

- Please initial: \_\_\_\_\_

I understand that I may be charged a \$75 no-show fee for scheduled appointments which I do not cancel at least 48 hours prior to my appointment and do not arrive within 15 minutes of my scheduled appointment time.

- Please initial: \_\_\_\_\_

### **Fax/Copy Policy**

I understand that Health Partners LLC reserves the right to charge me to print/fax/and or mail additional copies of patient records to patient or outside providers. I understand that I may be responsible for faxing charges for incoming records requested on my behalf, or by me, to be sent to Health Partners LLC. I understand I will be advised of any charge in advance of being charged. I will be given one copy of diagnostic lab results ordered through Health Partners LLC.

#### *Faxing and Records:*

New patients are allotted 20 pages of records requested to our office by fax with no charge.

An excess of incoming fax pages of 20 pages for records will be chargeable to the patient at \$0.25 per page.

Existing patients are allotted 10 pages of faxed records to our office per month.

An excess of 10 pages per month is chargeable to the patient at \$0.25 per page.

Copies of records in excess of 20 pages for patient record are also chargeable at \$0.25 per page.

There may be additional fees for review of records based on number of pages received.

- Please initial: \_\_\_\_\_

### **Provider Time**

Our Providers reserve the right to charge for time used in addressing a patient's case outside of standard appointments. Charges may include (but are not limited to): Appointments with patient, reviewing patient's external medical records, answering lengthy questions or emails from patient, receiving and processing requested documentation for patient such as insurance or disability claims or filing, and phone calls with patient.

- Please initial: \_\_\_\_\_

### **Refund/Return Policy**

I understand that there are no refunds for appointments or services performed at Health Partners LLC. Supplement purchases are final once products have been opened. Unopened products may be returned within 10 business days of purchasing them from Health Partners LLC. No refunds will be given for probiotics.

Products bought from online dispensaries associated with Health Partners LLC (Fullscript, Wellevate, etc.) cannot be returned to Health Partners LLC, and Health Partners LLC cannot issue refunds for these products. I understand it is my responsibility for return of product purchased through online dispensaries. I understand laboratory services paid for but not performed may be refunded. Laboratory kits may be returned to Health Partners if unopened.

- Please initial: \_\_\_\_\_

### **Insurance Documentation Requests**

Health Partners LLC does not accept, bill, or file with insurance, and does not have an insurance employee on staff. Therefore, it is up to the Providers discretion to determine what insurance documentation the Provider will complete upon patient request. Health Partners LLC reserves the right to charge for completing the following documents: prior authorizations, medical justification letters, and other insurance documentation requested. Patient will be notified in

advance of charges for these documents. There are no guarantees for coverage, and patient understands that they are responsible for forwarding and filing all documents with insurance.

- Please initial: \_\_\_\_\_

**Credit Card Policy:**

I understand that I may provide a valid credit card (the credit card has not expired and has not reached its available credit limit) to be retained on file to pay any balance owed for my medical products and services provided by Health Partners LLC. In the event that my credit card expires or has reached its limit, I am responsible to provide a new valid credit card. I further understand that the billing address for the credit card on file must match the address that appears on my monthly credit card bill or bank statement. I agree to pay such total amount charged in accordance with the agreement governing the use of such credit card. I hereby authorize Health Partners LLC to charge my credit card for payment of the products purchased and medical services rendered.

(Leaving credit card information with our practice is optional for standard in person appointments)

Name as it Appears on Credit Card: \_\_\_\_\_

Circle Card Type: Visa    Master Card    Discover    American Express

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Verification Number: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cardholders Signature: \_\_\_\_\_

**Phone and Virtual Appointment Credit Card Policy:**

I understand I will provide a valid credit card prior to the start of my phone and virtual appointments to Health Partners LLC and that charges will be made to my credit card directly after appointment, and Health Partners LLC may leave a voicemail communicating my charges if I am unable to be reached by phone.

- Please initial: \_\_\_\_\_

**By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the above terms and conditions.**

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_