GW CENTER FOR INTEGRATIVE MEDICINE
TOGETHER WE CARE, HEAL, EDUCATE

The Center for Integrative Medicine
Privacy Policy

- The Center for Integrative Medicine respects your privacy. Access to information about you, your treatment, payment, and all other matter will be limited only to those with legitimate need to know.
- In signing this statement you permit CIM practitioners and those in administrative role access to your chart, and other materials only to the extent necessary to schedule, plan, administer or follow up on your treatment (including payment).
    - Treatment: To provide you with the health care that you require, the Center may use and disclose your protected health information (PHI) to those healthcare professionals whether on the center's staff or not.
    - Payment: To get paid for services provided to you, or assist you in receiving reimbursement for services, the center may provide your PHI to a third party who may be responsible for your care. **For example**: The Center may need to give your PHI to a workers compensation administrator before they will adjust your claim.
    - Health Care Operations: To operate in accordance with applicable law and provide quality and efficient care, the center may need to comply, use and disclose your PHI. **For example:** The Center may use your PHI to evaluate the performance of its personnel in providing care to you.
- Information may be released to emergency personnel if, the judgment of CIM professionals, your life or welfare are in imminent danger.
- Release of information about you will be limited to parties and purposes legally required or authorized including but not limited to, Prevention or Public health activities to prevent or control disease; Prevention or reports of abuse, neglect or domestic violence; Health oversight in connection with criminal or disciplinary actions regarding a health provider; Subpoena; Law enforcement, Coroner or Medical examiner, Organ donation; Research, but only as aggregate or de-identified data unless you have signed an information consent to participate in a specific study; A version of threats to public health and safety, Military and veteran affairs; Workers compensation; National Security and intelligence.
- You are entitled to know who has had access to your information and for what purpose.
- You are entitled to see any health information we have on file about you and to amend it.
- If you have agreed that CIM may communicate about your care to another person or agency, we will assume that you have obtained a copy of that party's policy or that you do not wish to do so.
- If you have questions about your privacy rights, we are happy to respond to them.
- I understand and agree to these policies.

Signature: _____ Date: _____

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Center for Integrative Medicine

Informed Decision Statement

I understand that as a patient of the CIM I will be receiving treatments that are drawn from traditional healing systems, also known as "complementary" or "alternative" therapy. These modalities are not generally utilized in western allopathic medicine.

I understand that both the traditional healing therapies and allopathic medicine may be beneficial to me and I may use them simultaneously. I will make sure my providers in both systems are aware of my participation in order to assure continuity of care.

I also understand that CIM has an interest in tracking my progress and medical outcomes and that data about the Center's patients may be utilized by or shared with other practitioners or researchers in the field. **No information that identifies me individually will ever be disclosed to others.**

I also understand that by providing my email address I authorize CIM to email me periodic newsletter and to contact me with any clinical issues.

Your email address will not be disclosed to anyone out CIM except for newsletter managing company.

Signature: _____ Date:_____

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Patient Authorization and Waiver

I understand that CIM will not submit to insurance company for benefits on my behalf for services provided.

I understand that **I am responsible for paying the full amount,** for services provided to me by the Center For Integrative Medicine on date of the appointment.

If I am covered by an insurance plan, including Medicare, and elect to submit a claim for reimbursement for services rendered by CIM, I do hereby authorize the release to Medicare Part B or its agents (Social Security Administration and Health Care Financing Administration) or to my insurance plan, any necessary information needed to determine my benefits, upon written request by Medicare or agents or my insurance plan.

If I apply for and receive partial reimbursement for Medicare or my insurance plan for services rendered by CIM, **I understand that CIM is not required to reimburse me for the difference between my payments**.

I understand that this authorization will remain in full force and effect, and I permit a copy to be used in place of the original.

I certify that I have read, fully understand, and agree to the terms of this authorization and Waiver.

Patient/Legal Guardian/ Representative Signature: _____ Date: _____

Relationship to Patient Witness: _____ Date:_____

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GW Center for Integrative Medicine (CIM) Declares
If you have Medicare you must read and agree by signing this document

1. GW Center for Integrative Medicine employs variety of different practitioners of alternative and integrative medicine. The address is at 908 New Hampshire Ave, Suite 200, Washington DC, 20037, the telephone number is 202/833-5055, the national Tax ID # 52-2298074. For a period of two years beginning on the date that this affidavit is signed (the "Opt-Out Period") by office manager or any practice owner it will be bound by the terms of both this affidavit and the private contracts that CIM enter into pursuant to this affidavit.

2. CIM have entered or intend to enter into a private contract with patients who are a beneficiary of Medicare ("Medicare Beneficiary") pursuant to Section 4507 of the Balanced Budget Act of 1997 for the provision of medical services covered by Medicare Part B. Regardless of any payment arrangements CIM may make, this affidavit applies to all Medicare-covered items and services that CIM furnish to Medicare Beneficiaries during the Opt-Out period, except for emergency or urgent care services furnished to Beneficiaries with whom CIM had not previously privately contracted. CIM will not ask a Medicare Beneficiary who has not entered into a private contract and who requires emergency or urgent care services to enter into a private contract with respect to receiving such services, and CIM will comply with 42 C.F.R. § 405.440 for such services.

3. CIM hereby confirm that it will not submit, nor permit any entity acting on my behalf to submit, a claim to Medicare for any Medicare Part B item or service provided to any Medicare Beneficiary during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation for which CIM required to submit a claim under Medicare on behalf of a Medicare Beneficiary, and CIM will provide Medicare-covered services to Medicare Beneficiaries only through private contracts that satisfy 42 C.F.R. § 405.415 for such services.

4. CIM hereby confirms that it will not receive any direct or indirect Medicare payment for Medicare Part B items or services that CIM furnish to Medicare Beneficiaries with whom CIM have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare Beneficiary under a Medicare+Choice plan, during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation. CIM acknowledge that, during the Opt-Out Period, CIM services are not covered under Medicare Part B and that no Medicare Part B payment may be made to any entity for my services, directly or on a capitated basis, except for items or services provided in an emergency or urgent care situation.

Executed on January 1, 2020 by practice management of CIM

Patient Signature:
Date:

Name of Authorized practice representative: Tatiana Rosten
Date: January 1, 2020

Name of Center Opt-out: Center of Integrative Medicine
Date: January 1, 2020

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Appointment Cancellation Policy for New Patients

When you book an initial appointment with us, we first review your medical history forms and set aside up to 75 minutes to see you. We know you value your time, we kindly ask you that you value ours. If you cannot keep the appointment, please call or email us at least **two business** days between the hours of 9am-5pm in advance to avoid charges.

Late Cancellation(less than **TWO BUSINESS DAYS** or **NO SHOW** fee is **100%** of the provider's fee.) **(Business days are Monday-Friday 9:00am to 5:00pm)**

Credit Card Payment Authorization Form

Sign and complete this form to authorize GW Center for Integrative Medicine to charge your credit card for payment after **each** service visit.

By signing this form you give us permission to charge your credit card for the amount indicated on the bill on or after the indicated date.

Please complete the information below:

I, _____authorize GW Center for Integrative Medicine to charge my credit card account indicated below for the **100% of the provider's fee** on or after the Date this form is signed.

Billing Address:_____ Phone Number:_____

City, State, Zip:_____ Email:_____

Account Type: ____Visa ____MasterCard ____AMEX ____Discover

Cardholder Name:_____
Account Number: _____
Expiration Date: _____
CVV2(3 digit number on back of Visa/MC, 4 digit on the front of AMEX_____

Signature_____ Date _____

I authorize GW Center for Integrative Medicine to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/service performed at the center on the day of your visit. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

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Insurance information

We do not accept insurance for any services performed at the center; however some of the Labs will be submitted to insurance electronically

Please Provide Copy of Insurance Card

-Insurance Company:_____

-Insurance Claims Address:

Address 1:_____

City:_____State_____Zip Code:_____

-Plan Name:_____**(eg. PPO, HMO, Open Access)**

-Plan Type:_____**(eg. Medicare, Medicaid, etc.)**

-Provider & Benefits Phone Number:_____

-Order of Benefits: __ Primary __Secondary __Tertiary

-Insurance ID:_____ **Group ID: _____**

We do not accept insurance, however some of the Labs will be submitted to insurance electronically

Please sign if you understand that, GW Center For Integrative Medicine does not accept insurance.

Name: _____ Date: _____