IMPACT HEALTH – INTEGRATIVE MEDICINE AND PREVENTIVE CARDIOLOGY, P.C.

David Johnson, MD
Phone: (616) 928-0668
Email: DrDave@davejohnsonmd.com

Authorizations, Acknowledgments, and Consents

Notice: I do understand that David B. Johnson, MD ("Dr. Johnson") doing business as Impact Health: Integrative Medicine and Preventive Cardiology, PC is a separate entity from Grand Rapids Natural Health, LLC and conduct separate practices from each other. Dr. Johnson rents office space from Grand Rapids Natural Health, LLC. Grand Rapids Natural Health, LLC exercises no control over the practice of Dr. Johnson. I will not hold Grand Rapids Natural Health, LLC responsible for any actions or inactions of Dr. Johnson.

Treatment Authorization and Consent: I authorize and consent to medical and health care treatment of ____myself ____my minor child _____ by David B. Johnson, M.D. ("Dr. Johnson").

Dr. Johnson or his representative has explained to me the procedures planned for the treatment of my condition and the possible risk(s) associated with these procedure(s). I certify that Dr. Johnson has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment (including non-treatment), and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment.

I have been informed that testing for HIV (human immunodeficiency virus) AIDS, hepatitis, and/or other blood borne agents posing occupational risk may be performed on me without my consent if a health professional sustains an exposure to my blood or other bodily fluid. I understand that this testing is required by Michigan law and, should such testing occur, I will not be billed for it.

I further authorize the practice to dispose of at their convenience any specimens or tissue taken from my body during my medical treatment.

I consent to administration of such anesthetics as may be considered necessary or advisable by my physician.

Medical Records Release Authorization: I authorize Dr. Johnson to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program.

I also authorize any physician or health care provider I have seen, to release my records to Dr. Johnson. Such authorization is effective for a period of 1 year, and extends to records regarding my minor child, if applicable.

Privacy Statement: While Dr. Johnson is not required to follow the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA), he does respect your privacy and will only release medical information about you as permitted or required by law. Dr. Johnson is an independent contractor at Grand Rapids Natural Health and will uphold the privacy practices of Grand Rapids Natural Health.

By signing this form, I acknowledge that I have received a copy of the Grand Rapids Natural Health Notice of Privacy Practices. I understand that Dr. Johnson and Impact Health: Integrative Medicine and Preventive cardiology, PC agrees and upholds Grand Rapids Natural Health's privacy practice as stated in the Grand Rapids Natural Health Notice of Privacy Practices.

I give Grand Rapids Natural Health permission to subscribe me to monthly newsletters and promotional deals.

____ yes _____ no

Notice as to Possible Non-Coverage of Services: I understand that because of the non-conventional nature of Dr. Johnson's services, insurance reimbursement may not be available. My insurance company may not pay for acupuncture services, for example, and in some cases may not pay for office visits where the focus of the consultation is on wellness, herbal medicine, or other complementary and alternative ("CAM") medical services. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics may also not be reimbursed.

Services: Dr. Johnson provides direct payment fee-for service consultations and follow-up appointments. His fee schedule is available for review on his web page at www.DaveJohnsonMD.com. Additionally, Dr. Johnson has created several programs where service fees are bundled. This includes programs like his Cardiovascular Wellness Assessments and Healthy Hearts, Healthy Lives Transformation program. These are not typical fee-for service visits therefore traditional insurance reimbursement is unlikely to be available. The Healthy Hearts, Healthy Lives Transformation program is a prepaid 6-month program. More information is available on his web page at www.DaveJohnsonMD.com.

Financial/Insurance Responsibility: I understand that Dr. Johnson does not participate in any insurance plans, including Medicare and Medicaid. I understand and agree that Dr. Johnson does not take assignment, which means that payment in full will be required with each visit. I understand that I can request a superbill showing the cost and nature of services, and it will be my responsibility to submit these claims to my insurer. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Johnson to take action to secure payment of an outstanding balance owed. I acknowledge receipt of Dr. Johnson's current Fee Schedule.

Claim Management: I understand that it is my responsibility to know my insurance benefits. Dr. Johnson may offer some assistance, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect. Dr. Johnson will respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information.

Cancellation Fee: Please be aware that late cancellations or no-show appointments will be charged 50% of the appointment fee. It is requested that if you must cancel your appointment, that you provide more than 24 hours' notice. A cancellation is considered to be late when the appointment is canceled without a 24-hour advance notice. A "no-show", is a patient who misses an appointment without canceling it. This includes arriving 15 minutes after your scheduled appointment.

Any occurrence of a late cancellation or a "no-show" within 24 hours will be subject to a fee of 50% of the visit applied to the credit card stored on file 24 hours after the visit booking time. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Wellness program and Weight-loss program participant's cancellation policy:
Any occurrence of a late cancellation or a "no-show" will not receive a refund for their missed session, but will be given the option to make up the missed session by paying 50% of the non-discounted rate of the appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. In this instance, we may allow you to reschedule without an additional fee, but only with management approval.

Refund Policy (Membership Program): Dr. Johnson wants you to be happy with your treatment. Dr. Johnson has invested considerable time and effort into your Membership Program. If, for some reason, you are not satisfied and wish to stop or terminate from the Membership Program then no refund will be provided.

Notice to Medicare Patients:

1. Dr. Johnson is not excluded from Medicare under sections 1128, 1156, or 1892 or any other section of the Social Security Act.
2. I, or my legal representative, accept full responsibility for payment of Dr. Johnson's charge for all services furnished by Dr. Johnson.

3. I, or my legal representative, understand that Medicare limits do not apply to what Dr. Johnson may charge for items or services furnished by Dr. Johnson.
4. I, or my representative, agree not to submit a claim to Medicare or to ask Dr. Johnson to submit a claim to Medicare.
5. I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by Dr. Johnson that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
6. I, or my legal representative, enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and I am 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.
7. The expected or known effective date and expected or known expiration date of the opt-out period is from October 1, 2012 through September 30, 2014.
8. I, or my legal representative, understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
9. I, or my legal representative, am not entering into this contract during a time when I require emergency care services or urgent care services.
10. I, or my legal representative, acknowledge I will be provided a photocopy of this contract before items or services are furnished to me under the terms of the contract.
11. This contract will be retained with original signatures of both parties, by Dr. Johnson for the duration of the opt-out period.
12. This contract will be made available to CMS upon request.
13. This contract will be entered into for each opt-out period.

No Guarantees: I am aware that no practice of medicine is an exact science, and I acknowledge that no guarantees can or have been made to me as to the results of diagnoses, care, treatment, or examination by Dr. Johnson or his or her employees or medical staff of his practice.

Electronic Communications: I hereby authorize Dr. Johnson to communicate with me by electronic mail (email) and through live streaming video. I understand that an email sent to me by Dr. Johnson, or a live streaming video chat with Dr. Johnson, may include medical information about me. I further understand that an email message can sometimes be misrouted to or intercepted by an unauthorized third party, and that a streaming video may be intercepted by a third party, but I accept these risks. I understand that these methods of communication are not always private or secure.

Duration/Revocation of Authorizations: I understand that the authorizations and consents may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

I understand that any aspect of this form that I do not understand can be explained to me in further detail by my asking Dr. Johnson. I certify that this form has been explained to me and that I have read it or have had it read to me, and that I understand its contents. I also understand that a copy of this form is available upon my request.

Date: _____

_____ _____

Patient/Guardian Patient/Guardian Name Printed

_____

David B. Johnson, M.D