Consent for "Virtual" (Non-In-Person) Visits

Patient Name: ______________________________ Date of Birth: ____________________

I, ________________________ hereby voluntarily consent to receive "virtual" care. I understand that this consent form will be valid and remain in effect for as long as I am receiving medical care at ____.

Examples of the virtual services offered pursuant to this consent include:

Virtual check-ins: You and your treating provider may have a brief phone call to determine whether an in-person visit or other appropriate treatment is necessary.

E-visits: You may communicate with your treating provider through your patient portal or secure email.

Telehealth visits: You and your treating provider can use real-time interactive audio and video communication that permits real-time communication (such as FaceTime, Skype or What's App) to conduct a visit while you and your treating provider are in different locations.

"Virtual" or "Telehealth Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Because this type of consultation may be different from that with which you are familiar, it is important you understand and agree to the following statements:

- My treating provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the provider. _____ (initials)
- I understand that my voice and image may be recorded to assist in my treatment and I consent to any such audio and video recording. _____ (initials)
- I understand there are potential risks associated with this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are limitations to this type of care and that I may seek alternatives. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if either party determines that the videoconferencing connections are not adequate for my situation. _____ (initials)
- I understand that I may be disconnected before all my medical problems are known or treated. It is my responsibility to make such conditions or symptoms known to the medical personnel and to make arrangements for follow-up care. _____ (initials)
- I understand that standard deductible and coinsurance amounts apply to these "Virtual" or "Telehealth Visits" and I consent to virtual treatment. _____ (initials)

I have read and fully understand this **Consent for "Virtual" (Non-In-Person) Visits** and agree to its contents.

Signature of Patient or Person Authorized to consent for patient:

____ ____________

Signature Date

____

Printed Name (if other than patient)

☐ This Consent for Virtual (Not-In-Person) Visits has been provided verbally by the Patient.

Integrative Health Center of Maine

Offering the best of conventional and natural healthcare

15 Skyview Drive, Unit 200
Cumberland Foreside, ME 04110

ph: 207.699.3830 f: 207.699.3831
www.maineintegrative.com

Welcome to Integrative Health Center of Maine -- Introduction to the Practice

Congratulations -- you are taking an important step in helping yourself achieve a full and healthy life! We look forward to seeing you soon. In the meantime, please review this information packet for some important policies:

- Please continue to see your current primary care provider for ongoing health maintenance and screening testing, unless you specify that you want Dr. McCloy to take over your primary care needs.
- There is a $40 monthly membership fee that will be automatically charged to your credit card. This covers all the specialized services that Dr. McCloy current offers including direct communication access, 24 hour on-call coverage, medication refills, discounted laboratory pricing, and brief online inquiries. In appreciation of your ongoing support of our practice, members enjoy a 10% discount on all IV therapies!
- We use an electronic medical record platform called Hello Health which provides patients 24-hour access to their laboratory reports, medication and supplement lists, ability to book their own appointments, and secure communication with their providers. New patients can trial Hello Health free for 30 days with no obligation.
- Please bring in any medications and supplements you are currently taking. This will allow Dr. McCloy to have an accurate list and check for any unhealthy interactions. For instance, some supplement manufacturers do not adhere to strict quality control guidelines. By knowing exactly what you are taking, we can assist you in finding the safest, most effective, and least costly treatments.
- We have enclosed a Release of Information form to send to your provider's office. Note that it takes many providers' offices two to three weeks or more to send medical records to us -- allow plenty of time ahead of your appointment. If you have your own medical records, please bring them to your appointment.
- Dr. McCloy can give you a Superbill to submit to your insurance company for reimbursement. Please let us know if you need a Superbill or if you have any questions about how to submit information for reimbursement. Dr. McCloy can communicate with your insurance company regarding reimbursement appeals (if you request it), but he may charge for extensive time spent in communication and for chart printing.
- We often have therapy dogs in the office. **If you have a severe allergy to dogs, please notify us** ahead of time so we may accommodate you. Similarly, if you are not comfortable being around dogs, please let us know and we would be happy to isolate them during your visit. There is no extra charge for therapy dog services.
- Many of our patients have extreme sensitivities to multiple chemicals. Please do not wear scented products on the day of your visit. Please refrain from smoking 60 minutes prior to your visit.
- If you need to cancel or reschedule your appointment, be sure to do so at least one 24-hour business day prior to your scheduled appointment. **Otherwise, you will be responsible for full payment for your appointment.**
- We are a family-friendly office, but we do not have childcare services. If you are bringing children to your appointment, you will be responsible for their care. We strive to maintain a peaceful and nurturing environment -- if you think your children's behavior may be disruptive, please arrange for proper supervision.
- **Payment is expected on the day of the appointment**. Dr. McCloy does not participate in any form of insurance. We accept cash, check, Visa, Discover, and MasterCard. Most of Dr. McCloy's charges are based on the amount of time spent, including face-to-face or phone consultation, detailed email correspondence, or for extensive chart review (>15 minutes). Dr. McCloy also accepts Time Credits through Hour Exchange Portland at a 2:1 ratio. Outstanding unpaid balances will have standard interest rates applied after 30 days, unless otherwise arranged with the practitioner.
- **Please see the back side of this page for driving directions to our office.**

Please let us know if you have any questions. For more information, please visit our website: www.maineintegrative.com. We look forward to seeing you soon – thank you and be well!

We are easily accessible from Rt 95 (Maine Turnpike), Rt 295 and Rt 1 (specific directions below).
We are across from the Friend School of Portland, located at 11 US Rt 1, Cumberland.
Look for the school zone signs and flags.
As you are heading from Portland towards Cumberland on Rt 1, we a quarter of a mile past the European Bakery (on the opposite side of the street) and just beside the Falmouth Self Storage units.

DIRECTIONS FROM THE SOUTH:
FROM 295:
-Exit 10 towards Falmouth
-Turn left at the traffic light off the exit ramp onto Bucknam Road
-Turn left at the next traffic light onto US Rt 1.
-Drive 1.9 miles along US Rt 1 (passing European Bakery, Street Cycles and Falmouth Self Storage).
-Turn left onto Skyview Drive. (Right near the school zone signs and flags).
-We are the first building on the right- red and brown exterior.
-Park in the upper parking lot for IHCM

DIRECTIONS FROM THE SOUTH:
FROM 95 (Maine Turnpike):
-Exit 52 for Falmouth Foreside. Follow the turnpike spur.
-At the end of the Turnpike Spur stay in the left lane to merge onto US Rt 1 N towards Yarmouth
-Drive 1.5 miles along US Rt 1 (passing European Bakery, Street Cycles and Falmouth Self Storage).
-Turn left onto Skyview Drive. (Right near the school zone signs and flags).
-We are the first building on the right- red and brown exterior.
-Park in the upper parking lot for IHCM

DIRECTIONS FROM THE NORTH:
From 295:
-Exit 15 for US Rt 1 South toward Cumberland/Yarmouth
-Left onto US Rt 1 South and the end of the exit ramp.
-Drive 3 miles along US Rt 1 South
-Right onto Skyview Drive (Right near the school zone signs and flags).
-We are the first building on the right- red and brown exterior.
-Park in the upper parking lot for IHCM

DIRECTIONS FROM THE NORTH:
From 95 Maine Turnpike
-Exit 52 for Falmouth Foreside. Follow the turnpike spur.
-At the end of the Turnpike Spur stay in the left lane to merge onto US Rt 1 N towards Yarmouth
-Drive 1.5 miles along US Rt 1 (passing European Bakery, Street Cycles and Falmouth Self Storage).
-Turn left onto Skyview Drive. (Right near the school zone signs and flags).
-We are the first building on the right- red and brown exterior.
-Park in the upper parking lot for IHCM

Introducing Hello Health, the Electronic Medical Record (EMR) system for Integrative Health Center of Maine

Hello Health is an easy-to-use EMR system that allows access to all of your IHCM medical records including medication and supplement lists, lab results, notes from your provider, vaccination history, etc. It also allows you to send SECURE messages to your provider. Please keep in mind that email communication is not secure or confidential. Hello Health is HIPAA-compliant.

It is optional for IHCM patients to use Hello Health but we strongly encourage it. You pay an annual membership fee directly to Hello Health which offers a free 30 day trial.

Hello Health sign-up:

https://hellohealth.com/

Go to "Patient Portal" (top right corner)
Click "Get Started" (top right corner)
Click "Create an Account"
Enter information and "Submit"

To access visit notes:

1. Log into your account
2. go to the "Appointments" tab
3. Choose "Past" from the sub-menu
4. Locate the date of the visit you want to view. Click the green "Details" button to view the visit note that your doctor has shared with you.

If you have any question regarding portal issues, portal access, or portal billing please contact the Hello Health Portal team as 1-866-779-1526.

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Please complete the following information legibly and completely. Thank you!

First name:________________ Last name:____________________ Middle int.:_____

Billing address:_________________________________ DOB:________________

City:___________________ State:_________ Zip:_____________ Sex:________

Social Security #:_______________ Email Address:____________________________

Home Phone:________________________ Cell Phone:_________________________

Work Phone:_________________ Employer/Occupation:________________________

Relationship Status:______________ Partner's Name:___________________________

Emergency Contact:___________________________ Phone #:____________________

Primary Insurance Name:___________________________ Group #________________

Address:_________________________________ ID#:__________________________

City:_______________________________ State:________ Zip:_________________

Name of Guarantor:_________________________DOB__________________________

Primary Insurance Phone #:____

Secondary Insurance Name:___________________________ Group #:______________

Address:___________________________ ID #:_____________________________

City:_______________________________ State:____________ Zip:_______________

Secondary Insurance Phone#:____

Preferred Pharmacy: ___________________ City: _____________________________

Allergies:____

Medications____

please see reverse side

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I, ____, have been informed about the
Patient/Guardian name

Integrative Health Center of Maine Notice of Privacy Practices.

____ ____________________
Signature of patient/guardian Date

Many of our patients have chemical sensitivities. Please refrain from wearing any scented products including perfumes.

If you smoke, please refrain from smoking at least 60 minutes before entering the office.

____ ____________________
Initial of patient/guardian Date

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MEDICARE PRIVATE CONTRACT AGREEMENT
MEDICARE BENEFICIARIES

NOTE: YOU ONLY HAVE TO COMPLETE THIS IF YOU HAVE MEDICARE INSURANCE

Sean McCloy, MD, MPH, MA

I, ________________________________, am eligible for Medicare benefits. In consideration of my choice to see Sean McCloy, MD, MPH, MA, I choose and hereby agree to forego reimbursement from the Medicare program for any items or services incurred in Dr. McCloy's treatment of me. I understand, and it has been satisfactorily explained to me, that any medical services provided for me by Dr. McCloy will not be covered by Medicare, even if these services would be covered should I obtain them from another physician. I agree and acknowledge that I will be responsible for payment of any charges for items or services, including laboratory, incurred in my visits to Dr. McCloy. I understand that any secondary insurance I have may decide not to pay for services that could have been covered by a physician eligible to receive Medicare payments. I understand that Dr. McCloy has not been excluded from the Medicare program and remains in good-standing, but has voluntarily chosen to withdraw (opt-out) in favor of privately contracting for his services.

Specifically, I agree to the following:

1) I agree not to submit any claim for reimbursement under Medicare for any items or services even if such items or services are otherwise covered by Medicare;

2) I agree that I will not request or require Dr. McCloy submit a claim, even if I believe that a formal denial from Medicare for a particular service might allow me to receive coverage from a secondary policy;

3) I agree to be responsible, whether through insurance or otherwise, for payment of such items or services billed by Dr. McCloy. I understand that no reimbursement will be provided from Medicare for such items or services provided by Dr. McCloy, and that any determination by Medicare as to coverage or medical necessity for a given treatment or procedure does not affect my responsibility to pay;

4) I understand and acknowledge that the amount of Dr. McCloy's bills for his services are not subject to any limiting fees (including the limits under §1848(g)), and that Dr. McCloy may charge any amount for the items or services he supplies;

5) I understand and acknowledge that Medigap plans under §1882 do not, and other supplemental insurance plans may elect not to, make payments for such items and services because Medicare payments are not made;

6) I understand and acknowledge that I have the right to have such items or services provided by other physicians or practitioners for whom Medicare payment might be made, should it be determined that these services are covered and not excluded;

7) I hereby certify that this contract was not entered into at a time when I am facing an emergency or urgent health care situation.

8) I understand that I may receive a photocopy of this contract.

Date: ______________________ ____________________________
Sean McCloy, MD

____________________________ ____________________________
Patient Signature Witness Signature

____________________________ ____________________________
Patient Name Printed Witness Name Printed

As the legal guardian for the above-named patient, I understand and agree to the foregoing:

Date: ______________________ ____________________________
Sean McCloy, MD

____________________________ ____________________________
Guardian Signature Witness Signature

____________________________ ____________________________
Guardian Name Printed Witness Name Printed

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Advance Beneficiary Notice (ABN)

In plain English: this form says that you are aware that your health insurance company may not pay for our services. Payment is required at the time of visit.

Your health insurance company may not pay for the item(s) or service(s) that are described below. Some health insurance companies including Medicare do not pay for all your health care costs. They only pay for covered items and services when their rules are met. The fact that they may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your health care provider recommends it. Right now, in your case, your health insurance company may not pay for any of the following: Integrative Family Medicine, Intravenous Therapies, Nutraceutical/Supplement/Vitamin therapy, and/or Functional Laboratory Testing because any of these services may be considered "out of network" and/or experimental and/or not FDA-approved.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain if you don't understand why your health insurance company probably won't pay.
- Ask us how much these items or services will cost you.

I understand that my health insurance company may not pay for these services and that I am responsible for full payment at the time of visit. I have read and agree to the Practice policies in the Welcome letter. I understand that my insurance company will not decide whether to pay unless I receive these items or services. I understand that you may bill me for items or services and that I have to pay the bill while my health insurance company is making its decision. If my health insurance company does pay, they will reimburse me directly any payments I made to you that are due to me. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I understand I can appeal my health insurance company's decision. I understand I am fully responsible for all communication with my insurance company, and that if I ask IHCM to perform administrative tasks and/or communicate with my insurance company I will be charged for time spent at the usual rates.

NOTE: **Your health information will be kept confidential**. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your health insurance company, your health information may be shared with your health insurance company. Your health information that your health insurance company sees will be kept confidential by your health insurance company.

A Notice of Privacy Practices document regarding HIPAA policies for confidential and protected healthcare information is available upon request and can be found on our website. By signing below you acknowledge that you have been informed about our Notice of Privacy Practices.

I also attest that I am seeking care only for myself, and that I do not represent a third party.

______________________________________ __________________

Signature of patient/guardian Date

NAME (or ID) ___ ___ ___ ___ ___ ___ Date: ______/________/_________

<u>SYMPTOMS.</u> <u>During the past 2 weeks</u>, how much have you been **<u>bothered</u>** by any of the following?

Rate "bother" for the past 2 weeks	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. Shortness of breath	0	1	2	3	4
2. Feeling feverish	0	1	2	3	4
3. Sweats and/or chills	0	1	2	3	4
4. Nausea and/or vomiting	0	1	2	3	4
5. Back pain	0	1	2	3	4
6. Headaches	0	1	2	3	4
7. Stiff or painful neck	0	1	2	3	4
8. Muscle aches or pains	0	1	2	3	4
9. Joint pain or swelling	0	1	2	3	4
10. Muscle weakness	0	1	2	3	4
11. Feeling fatigued or having low energy	0	1	2	3	4
12. Feeling worse after normal physical exertion	0	1	2	3	4
13. Trouble falling or staying asleep	0	1	2	3	4
14. Needing more sleep than usual	0	1	2	3	4
15. Not feeling rested on awakening	0	1	2	3	4
16. Numbness or tingling	0	1	2	3	4
17. Shooting, stabbing or burning pains	0	1	2	3	4
18. Skin or muscle twitching	0	1	2	3	4
19. Discomfort with normal light or sound	0	1	2	3	4
20. Balance problems or sense of room-spinning	0	1	2	3	4
21. Change in visual clarity or trouble focusing	0	1	2	3	4
22. Bladder discomfort or change in urination	0	1	2	3	4
23. Light-headed or uncomfortable on standing	0	1	2	3	4
24. Hot or cold sensations in extremities	0	1	2	3	4
25. Irregular or rapid heart beats	0	1	2	3	4
26. Feeling irritable, sad, or decreased pleasure	0	1	2	3	4
27. Feeling panicky, anxious or worried	0	1	2	3	4
28. Trouble finding words or retrieving names	0	1	2	3	4
29. Trouble with memory	0	1	2	3	4
30. Slower speed of thinking	0	1	2	3	4

TOTAL SCORE (add all numbers): __________

Over the last 2 weeks, have any of the above impaired your work, social, or family functioning? Yes No

If Yes, please indicate the number (#) of each of the most impairing symptoms below, **starting with the most impairing (#1)**, then list the next most impairing (#2) and continue listing in descending severity other impairing symptoms.

1. ______ 2. ______ 3______ 4______ 5______ 6______ 7______