WILKINSON
WELLNESS CLINIC

Mission Statement:

With kindness and compassion, we seek to solve unsolved health challenges and restore vibrant living.

Our Commitments to Patients:

We commit to providing a positive, warm environment; making sure each patient feels heard and confident that Dr. Wilkinson and his staff are doing their best to assist them on their journey of reaching optimal wellness and healthy aging.

We commit to reaching beyond the boundaries of traditional medicine in our search to find the root cause of each patient's health challenge, thereby enabling us to better guide each patient in their quest for optimal health they so deserve.

We commit to a balanced approach that is proactive instead of reactive. This involves empowering our patients with education in elevating the mind, body and spirit through preventative measures such as nutrition, exercise, and personal growth.

We commit to physician and staff continuing education so that we may stay at the forefront of the natural technologies, and treatment modalities.

We commit to researching and providing high quality, pharmaceutical grade supplements which we will make available for our patients to purchase.

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PATIENT INFORMATION:

Today's: Date:_____

Patient Name:_____DOB:_____
Single Married Divorced Widowed Separated

Home Phone:_____ Cell:_____ Work:_____

Address:_____

City:_____ State:_____ ZIP:_____

Email:_____
(Dr. Wilkinson periodically sends out newsletters and clinic updates via email.)

Employer:_____ Occupation:_____

Business Address:_____

Spouse Name:_____

Employer:_____ Occupation:_____

Business Address:_____

INSURANCE INFORMATION:

Do you have medical insurance? **YES NO**
(Please note that we are NOT contracted with any insurance. We do NOT accept Medicare of any kind. Insurance information provided below is in case we need to send a referral.)

Name of Insurance:_____

Group #:_____Member #:_____

Names of those insured:_____

Insurance Address:_____

City:_____ State:_____ ZIP:_____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name:_____ Relation:_____

Phone Number:_____ Email Address:_____

Please Note:

Your appointment will not be booked until we receive completed copies of this "Application", "Medicare Opt Out Acknowledgement" and the "Pre-Authorized Use of Credit Card" form.

IMPORTANT: Out of respect for our chemically sensitive patients, please refrain from wearing perfume or scented products in our office. Thank You!

For Office Use Only:

Upon receiving was the following completed:

- New Patient appointment confirmed in system
- Copy of CC Authorization taken
- Physical chart created and labeled
- All preliminary paperwork placed in back of chart

X Date:

_____

Sign to confirm that paperwork has been received and appointment has been confirmed.

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New Patient Policy

Dear New Patient,

Thank you for calling on the Wilkinson Wellness Clinic to assist you in your quest for good health. We appreciate your trust in us and look forward to meeting you.

It is important to us that you have ample time, especially as a new patient, to share your concerns and symptoms and also have sufficient time to ask questions. Because of the quality of care that we give our patients, we schedule only a limited number of patients each day. In return, we are requesting that you show up for your appointment.

Since we schedule a large portion of time for each patient, we ask you to have the courtesy to give us **at least two (2) business days notice if you need to reschedule or cancel your appointment and future appointments**, so that we might fill that time with someone from our waiting list. **If you do not call the office two (2) business days before your scheduled appointment you will be charged 100% of the appointment fee.** We thank you for your cooperation in this matter.

In order to fully evaluate the factors involved in your individual health care, it is very important for you to fill out the enclosed forms before your appointment and bring them at the time of your appointment. Please read them carefully. The information is vital in addressing your needs.

If you have any questions regarding the provisions of policies, or any other aspect of your care, please contact our office. We will be happy to discuss any questions you might have.

It is our privilege to be of service to you.

Sincerely,

Richard S. Wilkinson, M.D.
The Wilkinson Wellness Staff

IMPORTANT: Out of respect for our chemically sensitive patients, please refrain from wearing perfume or scented products in our office. Thank You!

X DATE:

Please sign above that you have read, understood, and agree to our terms of care.

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Two decades ago, our medical system embodied the scientific method, valued the doctor-patient relationship and practiced from soul. Today, money and profit is what health care is serving. Neither health nor care is its goal. It is a 'sick care' system that manages symptoms in the 'name of health care'. The scientific method has fallen by the wayside. Health care today has become a 'closed system' where even scientific evidence of harm is sidestepped in the name of profit. Preventive medicine is a conflict of interest for this model. Symptom management does not involve patient education, lifestyle change, patient responsibility or healing. It involves using prescription drugs to manage symptoms.

"Today's health care consumer is waking up to the reality of this dark side of health care. When people experience the lack of care from their physician who practices under pressure within a corporate health care system, they look elsewhere for a doctor who can take the time to problem solve with them. Many people want more than what the current distortion of health care is offering. They want to learn what made them sick, how to heal, how to stay healthy and how to live consciously, This is what patients, the consumers of health care, deserve."

—Rose Kumar, M.D.

Dear Valued Patient,

I started this letter with the above quote because I have chosen for the last 35 years to practice medicine "from the soul...taking the time to problem solve" with my patients. In recent years, my ability to practice medicine has become more and more controlled by insurance companies. They tell both me, and you, just what kind of care you are going to receive. Little by little they are taking away choice and freedom...your freedom to choose what treatments you do and do not want and my freedom to ascertain what I think is the best protocol or methods to treat the patient sitting in front of me.

Concurrent with this loss of freedom are the demands for time that are being placed on myself and, especially, my staff, I have come to realize that to be free to truly give my best to my patients I need to discontinue contracts with insurance companies or price myself out of reach of those we have so faithfully served these last many years, or worse yet, close the doors. I do not care for those last two options. Therefore, as of January 1, 2019, I will no longer accept contracts with insurance companies. We will be happy to provide a super bill for you to self-bill your insurance company but we can no longer be party to their endless requests, denial of services, phone calls and never-ending paper work. I apologize if this news causes you distress. In anticipation of that, my wonderful staff has come up with some options that you may be interested in looking into as a healthcare alternative. We hope you will understand and trust this decision. It has been a long and extremely difficult decision to reach. The good news is that by discounting our association with you insurance company we will not be forced to substantially increase our prices this year!

May you be well,

Richard S Wilkinson, M.D.
Wilkinson Wellness Clinic

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Financial Policy

Thank you for choosing Wilkinson Wellness Clinic for your health care needs. The following is a statement of our Financial Policy. We ask that you please read it and require that you sign it prior to any health care treatment.

Regarding Insurance:
At this time, we are not contracted with any insurance. We are NOT a Medicare or Medicaid provider. All payments will be due at the time of service. We will be happy to provide you with a statement that you may submit to your insurance for possible reimbursement. Please be aware that some of the services and treatments we offer may not be considered to be reasonable or necessary by your insurance company.

Minor Patients:
The parent or guardian accompanying a minor is responsible for full payment at the time of the appointment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card or payment by cash or check at the time of the appointment has been verified.

Supplements:
All charges for supplements are due in full on the day of your appointment or at the time of purchase. Our doctor researches to find the highest quality supplements available on the market. We provide this service to help you on the road to good health and to save you time in finding them on your own. However, if at any time you desire to return a supplement, you are free to do so as long as it has not been more than 30 days since purchase, and the product is not expired. A refund or credit can be added to your account. Once it has been opened or has expired, we cannot accept it back or refund your money.

Lab Fees:
All lab test procedures are the financial responsibility of the patient regardless of what your insurance will cover. Please be aware that a check or Visa/MasterCard information must be enclosed with all labs or tests when they are mailed.

X **Date:**

_____

Signature of Responsible Party or Parent

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MISSED APPOINTMENT POLICY

We're glad you have chosen us to provide your medical care. If you miss your appointments, you compromise your care. We would like to remind you of our office policies regarding missed appointments.

A missed appointment is when you fail to show up for your appointment without notice, or failure to provide the required 48 business hours cancellation notice.

We try our best to be on time for our scheduled patients, and ask that our patients give us the same courtesy. If you are unable to keep your appointment, please call ahead to cancel so that we may fill that time with another patient. We have outlined our missed appointment policies below.

CHARGES FOR MISSED APPOINTMENTS

We require 48 business hours notice for all new and established patients and 24 business hours notice for all IVs since we premix all IVs the day before.

- New Patient Missed Appointment: The patient will be charged and must pay in full the entire office visit fee of $350.00 before being seen.
- Established Patient Missed Appointment: The patient will be charged and must pay in full the entire office visit fee of $165.00 before being seen again.
- Missed Appointment fee for IVs: The patient will be charged 50% of the cost of their missed IV.

Please be aware that 3 missed appointments may result in being discharged from our office.

_____ _____

Signature of Patient (or guardian if under 18) Date

_____

Printed Patient Name

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OUT OF NETWORK PROVIDER

I understand that Richard S. Wilkinson, M.D. and Wilkinson Wellness Clinic are not considered "In Network" with any insurance plan. _____ (Initial)

Should I choose to self-submit my medical receipt to my insurance company, I understand that depending upon my individual insurance policy, there may be no reimbursement for any services rendered by Dr. Richard Wilkinson or Wilkinson Wellness Clinic. _____ (Initial)

Should I choose to self-submit my medical receipt to my insurance company, I understand that depending upon my individual insurance policy, there may be a reimbursement for services rendered by Dr. Richard Wilkinson or Wilkinson Wellness Clinic and that reimbursement rate will be an "Out of Network" reimbursement. _____ (Initial)

I understand that if my insurance company is requesting copies of my chart notes and they are not willing to pay for WWC's staff time and resources to provide them this information, WWC will need to charge me 50 cents per page that is copied for the insurance company along with any postage required to mail this information. _____ (Initial)

I understand that the staff of Wilkinson Wellness Clinic will not submit any insurance billing on my behalf. _____(Initial)

I understand that all charges are payable in full at time of service. _____ (Initial)

_____ _____

Print Name **Date**

_____

Signature

_____ _____

Witness Signature (WWC Staff) **Date**

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a 'Privacy Rule' to help insure your Protected Health Information (PHI) is protected. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses/disclosures of PHI to carry out treatment, payments, or health care options.

As our patient, we want you to know that we respect the privacy of your medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, information will only be given to those we feel are in need of your PHI; as well as information about treatment, payment, or health care operations in order to provide healthcare that is in your best interest.

We also want you to know that we support and encourage your full access to your medical records. We may have indirect treatment relationships (such as pharmacies that need to confirm medical information to administer a medication) and you may have to disclose PHI for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under this law, we have the right to refuse to treat you if you refuse to disclose your PHI. If you choose to give consent in this document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.
You have the right to review our policy notice, to request restrictions, and revoke consent in writing after you have reviewed our Privacy Notice.

Print Name:_____ Signature:_____

Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients,

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for out patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

Our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!

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Pre-Authorized Use of Credit Card

I authorize Wilkinson Wellness Clinic to keep my signature on file and to charge my Visa / MasterCard / American Express for:

Balance of charges incurred through:

- **Unpaid clinic visit**
- **Unpaid phone appointment**
- **Phone Order of supplements, peptides, or other health remedies**
- **Missed appointment in accordance with the "New Patient Policy" and "Missed Appointment Policy"**

These charges will be run at the convenience of Wilkinson Wellness Clinic unless the patient has made other arrangements with an authorized staff member.

Patient Name | Cardholder Name *(If different than patient's name)*

Billing Address | City | State | Zip Code

Credit Card Number | Expiration Date | CVV Security Code

Cardholder Signature | Date

Authorized Staff Signature | Date

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Richard S. Wilkinson, MD

Are you currently on Medicare (circle one)? **YES NO**

- **If NO,** please read and fill out the form below acknowledging your understanding we are opted out of Medicare and if you enroll into Medicare during our Opt-out period, the following statements apply.

- **If YES,** please read and fill out the form below acknowledging your understanding of the following statements.

Section 4507 of the 1997 Balance Budget Act allows a physician or practitioner to enter a private contract with a Medicare beneficiary. Signatures from the provider, a witness and the patient/beneficiary or their legal representative are required below.

I, **Richard S Wilkinson**, have not been excluded from Medicare under sections 1128, 1156 or 1892 of the Social Security Act **1669765889** (provider's NPI)

I, _____, or my legal representative accepts full responsibility for payment of charges for all services furnished by **Richard S Wilkinson.**

I, _____, or my legal representative understands that Medicare limits do not apply to what **Richard S Wilkinson** may charge for items or services furnished.

I, _____, or my legal representative agrees not to submit a claim to Medicare or to ask **Richard S Wilkinson** to submit a claim to Medicare.

I, _____, or my legal representative understand that Medicare payment will not be made for ant items or services furnished by **Richard S Wilkinson** that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

I, _____, or my legal representative enter into this contract with knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has 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.

The expected or known effective date and expected or know expiration date of the opt-out period is **April 1st 2021** and **April 1st 2023**.

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Richard S. Wilkinson, MD

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.

This contract cannot be entered into by me, _____or by my legal representative during a time when I, _____ require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 3044.28 of the Medicare Carriers Manual).

I _____or my legal representative will receive or have received a copy or photocopy of this contract, before items or services are furnished to me under the terms of this contract.

I, **Richard S Wilkinson**, will retain the original contract for the duration of the opt-out period.

I, **Richard S Wilkinson**, will supply CMS with a copy of this contract upon request.

I, **Richard S Wilkinson**, understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Provider's NPI: 1669765889

Provider's Signature: _____ Date: 5/19/2022

Patient's Signature: _____ Date: _____

Patient's Legal Representative Signature: _____ Date:_____

Witness: _____ Date: _____