Restorative Health Clinic

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Telephone: 503-747-2021
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www.restorativehealthclinic.com

Clinic Policies

We strive for your experience at Restorative Health Clinic to be an excellent one. In order to achieve that goal we want you to be fully informed on our policies.

In order to keep our fees reasonable, we required full payment at the time of service for all office visits, supplements, and any treatment performed at our clinic.

None of our providers participate or are providers of any insurance company. Patients should not assume that insurance company will reimburse them fully for their office visit. Please contact your insurance company to obtain all the information necessary how to submit your claim for reimbursement.

Initial ____

Business Hours:

Restorative Health Clinic is open M-F from 9am to 5 pm, Friday. Please check with our office for actual Doctors office hours since they can vary from week to week.

Fees:

Initial Appointment for Chronic and Complex Cases ranges from 2hr ($700) to 2.5 hours ($800), the amount of time needed will be determined at the time of scheduling your appointment.

First Follow-Up Visit or Office Visit 60 min: $350

Follow up Visit of 45 min: $275

* Deposit of 50% is required to schedule a New Patient appointment.

** The above fees are only for office visit and does not includes any laboratory fees, supplements or other services.

In order to make the best use of your time with the doctor we encourage you to write down any questions, concerns, and other discussion points for your visit. Also, please bring an update list of supplements, medication, and symptoms to each of your visits.

We accept payment by cash, check, American Express, Visa, MC, Discover. Checks that are denied for lack of funds will incur a fee of $75.00.

We reserve the right to make changes in our fees and/or policies without advance notice.

Initial _____

Cancellation Policy:

We require a 48hr notice for established patients for Office Visits, IV, or other treatments. If we don't received a cancellation notice there will be a $75 charge. For all new patients visits a notice of 5 business days is required to obtain full refund of their deposit. If cancelation is done in less than 5 business day deposit will be lost. Cancellation notices are not accepted the night before or during the weekend.

Initial _____

Primary Care:

Patients should maintain a primary care physician for any emergencies and for their routine medical needs. All patients are required to have a primary care physician. Our clinic does provides an on-call after hour services but we do not provide emergency medical service or admit or care for patients in the hospital.

Initial _____

Phone/Emails Consults:

email correspondence is not appropriate for urgent medical needs and it is not intended for medical advice or diagnosis

•E-mail or "Passport" communication that requires 5 minutes or more of attention from your physician will incur a fee.

- 5 min of email correspondence $50*
- 10 min of email correspondence $75*
- 20 min of email correspondence $150*

*When the answer is a simple YES/NO there will not be a charge.

•All emails will be responded to with in **72 hrs**. If you need immediate response or medical attention, email is not the right communication tool. We suggest that you schedule an office visit or phone appointment with one of our physicians.
•Phone calls requested by patients are considered "Phone appointments" and they are charged to patients as regular Office Visits. Credit card information will be required at the time of scheduling and will be charged at the end of the day. Same cancellation policy will apply to phone appointments.

- 30 min phone consultation fee $200
- 40 min phone consultation fee $235
- 60 min phone consultation fee $300

Initial ____

Letter and Correspondence:

At times, we are asked to fill out forms for work, insurance companies, other physicians, etc. In order to comply with these requests in a timely manner we charge a minimum of $35 and they can vary depending on the size of the charts or documentation to fill out.

Initial _____

Prescriptions:

Any prescriptions refill request should be done directly to your pharmacy. Please allow 48 to 72 hours for processing.

Any new prescription will required an office visit with no exceptions.

Any refill of controlled substances requires an office visit with no exceptions. Please make sure you schedule your routine appointments ahead of time to avoid a delay on getting your prescription renewed.

You are responsible for ensuring continuity of treatment and we ask you to be in charge of your prescription's schedule to avoid interruption of treatment.

Initial ____

Medical Records:

Your medical records are subject to HIPAA policies. We need direct consent in order to release records regarding your care with us. Please make sure you sign a consent form in order to have your records released to your primary care physician or any other person/entity.

Initial ____

Purchase and Return of supplements or medical supplies:

All items must be paid at the time of purchase. Supplements can be returned for full refund if they are unopened and it is with in 30 days of purchase.

Credit will NOT be given for items returned after 30 days or for any opened supplement. Refunds cannot be made on injectables, injection supplies, refrigerated products, and enemas.

Initial ____

Mailing items:

We can mail you anything you need from our medicinary or other medical items supplies. A shipping and handling fee will be applied to the total prepaid amount. Refrigerated items can be shipped with an expedited fee. For any expedite package or letter an extra $25 fee will occur. Please arrange any mail-out with our office staff at 503-747-2021.

Initial ____

Special Order items:

Any special order will required a $25 deposit and will be adjusted accordingly once the actual price and item is received.

Initial ____

Restorative Health Clinic is a Fragrance-Free clinic.

If you have any questions do not hesitate to ask our staff. We are here to serve you and to help you on your wellness journey.

I understand the policies and procedures in place in and I agree to abide by them.

Signature _____Date _____

Patient Name (please print) _____