## Authorization & Acknowledgements:

**NOTICE AS TO NATURE OF SERVICES**: I understand that the care I receive from Dr Robban Sica may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine, or innovative services. Many of these services may not be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my physician may request laboratory testing which may include venipuncture, analysis of stool, urine, saliva and breath.

**NOTICE THAT SERVICES ARE NOT PRIMARY CARE***: I understand that Dr. Robban Sica is not acting as my primary care physician.* As such, emergency services are not offered. I understand that even though Dr. SIca may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully apprised of all available conventional means to address any medical conditions I may have. This is also important because this practice are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children. I also understand that it is my responsibility to inform Dr. SIca who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed by Dr. Sica in order to properly and safely coordinate my care.

**FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL THE CENTER FOR THE HEALING ARTS, PCSERVICES**: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at each visit; Dr Sica does not accept insurance assignment or Medicare. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses because differences between integrative and conventional medicine can lead to differences in views about medical necessity. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory and/or other clinical and diagnostic testing and/or services requested by Dr. Sica. This office will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Sica to take action to secure payment of an outstanding balance owed.

**NOTICE TO MEDICARE PATIENTS**: Dr. Sica has opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed**.** I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said services(s).

**CLAIM MANAGEMENT**: Dr Sica may respond to insurance requests for information at her discretion, 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. Insurance claim forms and information will be provided to patients at the time of visit or sent to you upon the availability of the appropriate documentation.

**FURTHER NOTICES AS TO POLICIES REGARDING INSURANCE**: At your request, Dr. Sica's staff at The Center for the Healing Arts, PC will provide claim forms for submission to insurance; submission shall be the patient's responsibility. Claim submissions may or may not be for covered services and may or may not include procedural codes or other data sufficient to support my insurer's determination as to what services it will reimburse. The Center for the Healing Arts, PC may provide records requested by my insurance company. If possible, The Center for the Healing Arts, PC will advise whether my insurance will cover any particular

expenses, but given the uncertainty that pervades insurance decisions, Dr Sica and The Center for the Healing Arts, PC cannot be responsible for any information that turns out to be incorrect.

**NO GUARANTEES**: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive from Dr. Sica.

**REVOCATION OF AUTHORIZATIONS**: These authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

**PATIENT ACKNOWLEDGMENT**: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

# Payment for services is expected in full at the time they are rendered

## Payments may be made by cash, check, MasterCard, VISA, or Discover

- This office does not participate with any HMO, PPO, POS, Medicare, or insurance plans.
- We do not accept assignment or submit insurance claims.
- ***We do NOT participate in Medicare or Medicaid.***
- **Fees may change without notice.**
- **Any accounts over thirty days will accrue with interest at the rate of 1.5% per month, plus additional late fees.**
- **Accounts delinquent over 90 days are due in full and will be referred to collection. All collection costs and legal fees will be added to the account.**

Listed below are examples of current costs and insurance coverage:

| Service | Approximate Range of Costs | Insurance coverage |
|---|---|---|
| **INITIAL OFFICE VISIT** | 195.00 – 475.00 | Covered to contract limits |
| ***NOTE: The cost of Lab testing and supplements are in addition to the cost listed for the office visits. However, if recent tests have been done, we strive not to duplicate. Please have these reports made available to us.*** | | |
| **SUBSEQUENT OFFICE VISITS** | 175.00– 450.00* | Covered to contract limits |
| *Based on complexity and treatment decision-making criteria as well as time spent, including patient education. *Additional charges will apply for visits requiring > 30 mins.* | | |
| **LABORATORY TESTING** | 200.00-1,000.00 | Covered to contract limits |
| *Varies by individual treatment plan.* | | |
| **SUPPLEMENTS** | 50.00 to 200.00 per month | Usually not covered |
| Determined by individual treatment plan. | | |
| **ANY PHONE CONSULTATION** | 115.00-275.00* | Usually not covered |
| *We reserve the right to charge whether or not the phone consultation is scheduled. Prorated based on complexity and treatment decision-making criteria. *Additional charges will apply for visits requiring > 30 mins.* | | |
| **INTRAVENOUS THERAPY** | 90.00 or more per treatment | Variably covered |
| ***IV's are pre- mixed to your individual needs and you will be charged a $70 fee without 24-hour cancellation notice.*** | | |
| **ALLERGY TESTING & TREATMENT *** | | Covered to contract limits |
| *Varies by amount, type of testing and treatment* | | |
| $450 per allergy panel, plus immunotherapy | Immunotherapy price range: $45/$95 per vial | |
| ***NOTE *IF ALLERGY TESTING , VIALS AND OFFICE VISIT ARE SCHEDULED SAME DAY, SOME INSURANCE COMPANIES WILL ONLY PAY FOR ONE SERVICE.*** | | |
| **Requests for:** Letter/Report $50-500/(minimum $50 per page) | Copies/Documents $.65 /page | Usually not covered |

**CANCELLATION AND/OR NO-SHOW POLICY:**

- **The Center urges you to keep every appointment, as consistent treatment provides optimal benefit.**
- **In the event you need to cancel an appointment, we require at least 48 hours notice (Mon – Thurs).**
- **Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a charge not less than fifty percent of the full visit fee for each occurrence.**