



Consent for Treatment and Patient Medicare/TRICARE Status

Patient: _____ Date: _____

I, _____ (for) _____
(Patient, parent or guardian of minor) (Patient name)

do hereby voluntarily consent to receive care at the Pfeiffer Treatment Center, including physical and laboratory examinations, tests, diagnosis and treatment by Allen T. Lewis, M.D., Terri McCreedy, CNP, Yanina Rabinovitch, CNP, Dawn Boyd, CNP and Tracy Ziemann, PA-C.

- Does the patient have Federal Medicare? (check one) Yes No
- Does the patient have Federal TRICARE Insurance? (check one) Yes No

- I am aware that Pfeiffer Treatment Center is not a Medicare or Medicaid provider. (As of 10/1/99 the physicians and practitioners at the Pfeiffer Treatment Center have opted out of the Medicare Program as provided in Section 4507 of the Balanced Budget Act of 1997.)
- I am aware that Pfeiffer Treatment Center is NOT an Authorized TRICARE provider.
- I have informed the Pfeiffer Treatment Center of my Medicare or TRICARE status. I am aware that it is my responsibility to inform the Center if I become eligible for Medicare or TRICARE in the future.
- The patient is responsible for all charges generated for medical care, laboratory fees or pharmacy purchases, and payment in full is due at the time of service, regardless of insurance coverage.
- I am aware that all laboratory testing must be completed through the Pfeiffer Treatment Center unless previously authorized by a Pfeiffer physician or medical practitioner.
- The Pfeiffer Treatment Center is a not-for-profit 501(c) 3 organization.
- We use conventional CPT Codes for billing our services, based on the limitations of the American Medical Association CPT Coding Guide. The patient is furnished with an itemized bill which they may submit to their Insurance Company, when appropriate. Insurance Support is available to guide you with insurance problems; however there may be a cost involved for some special request letters and forms.
- I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of the examination, tests, diagnosis or treatment by the Pfeiffer Treatment Center.
- I am also aware that the Pfeiffer Treatment Center recommends that medications should NOT be discontinued without the consent of the prescribing physician.
- I am aware that the Pfeiffer Treatment Center does NOT recommend that pregnant or nursing mothers take nutrient therapy.
- I am aware that a follow-up evaluation at the Pfeiffer Treatment Center or a Pfeiffer Outreach Clinic will be required to obtain a refill on a compounded nutrient prescription.

This form has been fully explained to me and I certify that I understand its contents and the purpose thereof.

(Patient or Parent Guardian if Patient is a minor)

I certify that this form and the procedures involved have been fully explained to the above.

(Witness) Pfeiffer Treatment Center Staff Member