Financial Agreement Self-Pay

I, understand that the services offered in the practice of Ryan D Zaklin, MD, MA, PC are not covered by my current insurance plan carrier and therefore accept responsibility for payment of services at the time service is rendered. Furthermore, I understand that my current insurance plan will not be billed on my behalf for fees paid.

If you have Medicare as a primary insurance please notify our office prior to your scheduled appointment. A private pay contract must be signed by any Medicare Beneficiary in order to be seen in our office by Ryan D Zaklin, MD, MA, PC, as these services fall outside the scope covered by Medicare.

Financial Statement:

As patient of Ryan D Zaklin, MD, MA, PC I understand that I am responsible for the payment of services received. I agree to keep my account current and will pay at the time of scheduling my appointment. I will notify the office 48 business hours in advance if a cancellation or reschedule is necessary, otherwise I understand that payment is refundable, minus a $50 cancellation fee, up to 2 weeks prior to the appointment. If I miss an appointment or fail to cancel prior to 2 business days before your appointment, I realize I may be charged a $100 fee.

If you are unable to keep your scheduled appointment, please notify our office at least 48 business hours in advance so that we can accommodate our other patients with a vacant appointment. For continuity of care it is recommended that you reschedule your appointment at that time. Failure to provide our office with 48 business hour notification will incur a missed appointment fee and/or loss of deposit. Being more than 15 minutes late may result in the need to reschedule your appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. In this instance, we may allow you to reschedule without an additional fee, but only with management approval.

Patient Name: **Signature**: **Date**:

MEDICINARY DISCLAIMER

I, _____, fully understand that the statements and treatment plan regarding supplements discussed with me by Ryan D Zaklin, MD, MA, PC not have been evaluated by the FDA. Some of the supplements recommended are to support the body's system functions. There may be adverse effects and contraindications to any one of these supplements that are recommended. These products are not intended to diagnose, treat, cure or prevent any disease.

Ryan D Zaklin, MD, MA, PC does not claim that any or all of the products suggested will stimulate, maintain, regulate or promote structure of the body or restore normal or correct abnormal function. I also understand that I am not obligated to buy any or all supplements at this location. I am free to obtain them from other sources if available, but further understand Ryan D Zaklin, MD, MA, PC cannot guarantee the efficacy of supplements from outside sources, which may impact treatment.

_____

Patient Name: **Signature**: **Date**:

Ryan D Zaklin, MD, MA, PC

Therapeutic Agreements and Confidentiality Statement.

As a practitioner, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of the people who I work with. I believe it is my responsibility to:

1. Assess each person's situation based on the information they provide
2. Assist them to sort through their health-related challenges
3. Provide information and options about treatment modalities that are available
4. Support them to make conscious decisions regarding their health
5. Develop, implement and support a plan of care that will promote physical, mental and spiritual health
6. Evaluate the effectiveness of a plan of care
7. Make referrals to community resources as appropriate

As a Ryan D Zaklin, MD, MA, PC patient, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of my own physical, mental and spiritual health. I believe it is my responsibility to:

1. Provide Ryan D Zaklin, MD, MA, PC with information that is relevant to my health

2. Be willing to sort through my health-related challenges

3. Ask questions related to treatment options and information that is provided. If supplements are mutually agreed as part of my treatment plan, take them only according to directions given to me and discontinue use if side effects ensue and report this to Ryan D Zaklin, MD, MA, PC

4. Work together with my Ryan D Zaklin, MD, MA, PC to develop a plan of care that incorporates goals that are meaningful to me and will promote my physical, mental and

spiritual health

5. Make conscious decisions to nurture intrinsic healing and promote balance in my life
6. Evaluate the effectiveness of my plan of care
7. Participate in all scheduled appointments
8. Abide by the office policies of Ryan D Zaklin, MD, MA, PC

CONFIDENTIALITY STATEMENT

As a Ryan D Zaklin, MD, MA, PC patient, I understand that what I discuss with Ryan D Zaklin, MD, MA, PC will be treated confidentially in accordance with law and recognized professional standards. I understand that only I can give up my right to privacy by signing a release of information. I understand that if my safety or the safety of someone else is at risk, my Ryan D Zaklin, MD, MA, PC is legally obligated to respond by sharing this information with the appropriate resources. For example:

> Licensed Social Workers, Nurses and Physicians are mandated by Massachusetts State Law to report any suspicion of child abuse to the New York State Registry
>
> Inform someone close to the client if they feel the client might harm him/herself or anyone else

Ryan D Zaklin, MD, MA, PC believes that the concept of integrative medicine works best when Ryan D Zaklin, MD, MA, PC discusses his work with other consultants, peer review, and/or supervision. This allows each client to benefit from the combined insight, knowledge, skill and experience of Ryan D Zaklin, MD, MA, PC and his colleagues. I understand that discussions of this nature would not include identifying information beyond a "need to know" basis, and such discussions would have the same privilege of confidentiality as sessions with each individual practitioner.

STATEMENT REGARDING CRISIS MANAGEMENT AND EMERGENCY MEDICAL CARE:

I understand that Ryan D Zaklin, MD, MA, PC for Integrative Medicine does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis I must obtain service that are appropriate to the type of crisis I am experiencing. If I am experiencing severe, acute symptoms or feel a life-threatening illness I will call:

911

My local hospital emergency room

My local police or fire department

Statewide Emergency Services Program (ESP):
Toll Free 877-382-1609

Patient Name:_____

Signature:_____ Date:_____

CANCELLATION POLICY for MEDICAL APPOINTMENTS

Please note that the Zaklin Center's cancellation policy is in place to make certain that all our patients maintain continuity of care, and to ensure that all of our patients have the ability to see Dr. Zaklin in a timely manner. It is our goal to provide the highest quality of care to our patients and in doing so, following up in a timely manner is necessary – last minute cancellations does not allow Dr. Zaklin to maximize his opportunity to follow up with his patients, nor allow patients waiting to be seen to be called in a timely manner

I _____, understand that if I am unable to keep my scheduled appointment, I will notify Ryan D Zaklin, MD, MA, PC 48 hours in advance so that an accommodation is able to be made for other patients with the vacant appointment. I understand that failure to provide Ryan D Zaklin, MD, MA, PC with 48 hours' notice, will result in a $100.00 cancellation fee (or loss of deposit) to be assessed. I further understand that my account must be brought into balance, prior to rescheduling a missed appointment.

Print Name:_____
Signed:_____

Electronic Communications:

I hereby authorize Dr. Zaklin to communicate with me by electronic mail (email) and through live streaming video. I understand that an email sent to me by Dr. Zaklin, or a live streaming video chat with Dr. Zaklin, may include medical information about me. I further understand that an email message can sometimes be misrouted to or intercepted by an unauthorized third party, and that a streaming video may be intercepted by a third party, but I accept these risks. I understand that these methods of communication are not always private or secure.

Terms of Use: Email

Ryan D Zaklin, MD, MA, PC for Integrative Medicine offers our patients the opportunity to communicate via email through the onpatient patient portal at www.onpatient.com . The utilization of email communication will allow your questions to be answered in the most efficient and accurate manner possible. All medical questions transmitted through email will be discussed with Dr. Zaklin so that your distinct and specific needs are addressed when responding to your inquiries.

Due to the volume of emails received, please allow 72 hours for a return email from our staff. Our staff will make every effort to read and respond promptly to emails received.

Please do NOT use email for medical emergencies or other time sensitive matters, as these matters require more immediate attention. Emergencies can be classified as: severe abdominal pain, severe and persistent headache, shortness of breath, excessive bleeding, chest pain and signs of infection – if you are experiencing these symptoms, please contact your PCP or local emergency department. Under each of these circumstances, patients should seek direct medical care.

Nor should email be used when back and forth correspondence becomes prolonged. Emails are not to be used in place of a follow up appointment or phone consultation.

Please be as succinct as possible in your questions: please do not email more

than 2 questions; please refrain from emailing complex questions or inquires that would require a significant change in treatment plan. A maximum of 2 emails per week, and not more than 100 words per email, will be addressed through our email system. *If your health concerns require a change in clinical therapy or an extensive follow up, we ask that you schedule a telemedicine or a face-to-face appointment for situations that require additional attention will ensure that you receive the highest quality of care at our Center*.

I have read and understand the information above, and agree to the terms of use for Ryan D Zaklin, MD, MA, PC email system.

_____

Patient Name: **Signature**: **Date**:

Consent to Use E-mail to Exchange Personally Identifiable Information

Name: _____ E-mail Address: _____

D.O.B. _____

I understand that sometimes the nursing staff will communicate with me through email. I further understand that, though emails via the onpatient patient portal are HIPPA compliant, this form of communication of personally identifiable information concerning my treatment may be used with technology without the use of encryption, and thus maintains its associated risks.

Sending personally identifiable information by e-mail has a number of other risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the individual.

E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.

E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.

E-mail content can be changed without the knowledge of the sender or receiver.

Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.

Employers and online service providers have a right to check e-mail sent through their systems.

E-mail can contain harmful viruses and other programs.

Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I, _____, authorize the practice to communicate with me at my e-mail address, _____, concerning my treatment. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

_____ _____

Patient Name: **Signature**:

Date:

Patient Compliance and Guidelines for Contacting the Office

In order to best serve all our patients, please read and retain a copy of these guidelines for contacting our office for the following matters. The care a patient receives depends partially on the patient. Patients have a responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her. Ryan D Zaklin, MD, MA, PC advises patients to attend their consultation with an advocate in order to ensure understanding of their treatment plan.

Questions for your Practitioner:

I acknowledge Ryan D Zaklin, MD, MA, PC medical staff is seeing scheduled patients during the day, and there is not always ample time to take my call directly regarding routine questions. Therefore, I will leave a detailed message on the medical voicemail line.

I agree and understand that I am to allow up to 72 business hours for a return call. I further acknowledge that medical questions left by voicemail are reviewed and will be prioritized by level of urgency.

I agree that if it is an emergency I will not leave a voice message; if I am unable to speak with a member of Ryan D Zaklin, MD, MA, PC directly, I will call my local emergency facility or urgent care center for emergencies.

Ryan D Zaklin, MD, MA, PC office hours for incoming calls are 9:00am-5:00pm Monday through Friday

_____ _____

Patient Name:

Signature: **Date**:

NOTICE TO MEDICARE PATIENTS

1. I understand that while Dr. Zaklin does accept Medicare in his other practice setting, the services provided by Ryan Zaklin, MD, MA, PC are not covered by Medicare.
2. I, or my legal representative, accept full responsibility for payment of Dr. Zaklin's charge for all services furnished by Dr. Zaklin.
3. I, or my legal representative, understand that Medicare limits do not apply to what Dr. Zaklin may charge for items or services furnished by Dr. Zaklin.
4. I, or my representative, agree not to submit a claim to Medicare or to ask Dr. Zaklin to submit a claim to Medicare.
5. I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by Dr. Zaklin that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ _____

Patient Name:

Signature:

Date: