Practice Guidelines and Patient Financial Policies

Roots Of Health
Lonna Larsh, MD
Amber Weiss, PA-C, LAc
709 Frederick St.
Santa Cruz, CA 95062

__ 1. Payment policy: We collect payment at the time of services. We expect payment in full. We accept cash, check, credit card, and PayPal. At your request, we will give you a receipt, also known as a superbill, which you may submit to your insurance company for reimbursement for the office visit. Most insurance companies will reimburse you (at the out-of-network rate), unless you have an HMO. If you have an HMO, we are happy to see you, but you will need to pay out of pocket for all services. Phone consults are not typically reimbursed by insurance. It is your responsibility to understand the details of your insurance plan. In addition to office charges, there may be separate charges for supplements and some specialized lab tests. Your provider will inform you on your cost for these.

__ 2. Medi-Cal: We are not able to bill Medi-Cal, but you can still see us if you choose to pay out of pocket.

__3. Medicare: We have chosen to opt out of Medicare. This means that we cannot bill Medicare for anything, anytime, ever, and that you cannot request that Medicare reimburse you for our services. If you have Medicare and receive our services, you will be personally responsible for 100% of the charges. We will need you to sign a contract agreeing to this. In addition, if you have a secondary insurance, they will not pay. The way the system is set up, secondaries will only pay after Medicare has paid their share. Since we are not billing Medicare, secondaries refuse to pay at all as well.

__4. Cancellation policy: As a courtesy to other patients seeking services, we require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation. There is a $50 fee for any late cancellations or missed appointments. You are responsible for remembering your appointment, whether or not you receive a reminder. A pattern of late cancellations and missed appointments may result in discharge from the practice.

__5. Bounced checks: There is a $50 fee for all bounced checks. If a check is bounced, all future appointments will be paid by cash only, at the time of service.

__6. Hospital care: We are no longer seeing patients in the hospital. If you need hospitalization, we have an arrangement worked out with the Dominican Hospital staff to take care of our patients.

__7. Emergencies: In the event of a medical emergency, please call 911 or go to your nearest emergency room. We do not have the equipment to handle medical emergencies in our offices.

__8. Release of medical information: Insurance companies may request records from us. Signing this authorizes the release of your medical information to your insurance company(ies) concerning any illness and treatment if it is requested by them.

__9. HIV/Hepatitis testing: Whenever a person rendering health care is directly exposed to a patient's body fluids, or a patient comes in contact with the caregiver's body fluids, in a manner that may transmit the HIV or hepatitis virus, such a patient or caregiver is deemed to have consented to testing for HIV or hepatitis virus without written consent. The results of these tests may by law be released to the exposed individual without the other individual's consent.

__10. Prescriptions and supplements: You are responsible for knowing when your medications or supplements need to be refilled. Please let us know at least 1 week in advance. Medications are refilled only at your visit or when requested in advance through your pharmacy. Unopened supplements can be returned within 30 days for a full refund or within 90 days for a supplement credit. Opened supplements purchased may be returned within 2 weeks for a credit of 50% of the amount paid.

__11. Form fees and letters: Most standard forms and letters that require more than a quick signature will be filled out at a charge of $20. This amount is not covered by insurance and is due at the time of service. There may be additional fees for particularly long and arduous forms/letters that require extensive time to fill out or write. We will notify ahead of time if there will be additional fees.

__12. After hours: If something urgent comes up during normal business hours, we will make every effort to be available to help you as quickly as possible. After hours availability cannot be guaranteed. See below for best ways to communicate with your practitioner.

__13. Communication with Amber Weiss: The quickest way to reach Amber is by text message (at 831-824-4005). Text is appropriate for anything that is urgent. If something is important, but not urgent, email (amber@rootsofhealthsc.com) is the best way to communicate with Amber, especially if you have a lengthy update or question about your health. She will answer phone calls whenever possible, but does turn her phone off at night.

__14. Communication with Lonna Larsh: Please call the office line (831-421-0775) or email (lonna@rootsofhealthsc.com) for routine matters. If you need to reach Dr Larsh urgently, call her cell phone or text (831-421-1292).

__15. Patient discharge: The practice reserves the right to discharge a patient for any reason, including failure to meet your obligations under this document or complete failure to comply with the treatment plan outlined by your practitioner.

__16. Current rates for Amber (for in-person, virtual or phone consultations):
New adult patient visit (90 min): $295
New pediatric visit (20-40 mins): $195.
Extended visit (40-50 mins): $150.
Standard visit (20-30 mins): $135
Simple visit (10-15 mins): $95 (only for patients seen in the past year)
Acupuncture (30-45 mins): add $40 to any visit
Vaccine risk assessment (20-30 minute phone consult): $135
If you need more than the time allotted during the visit, the additional time is prorated at $120/hr.
These rates are subject to change over time.

Current rates for Lonna (in person or phone):
New adult patient visit (120 min) $400
New pediatric visit (60 min) $235
Extended Visit (60 min.) Most visits will be this level $165
Moderate Visit (30 min.) $150
Simple Visit – Returning Patient seen in the last year (15 min.)$110
Annual Wellness Visit w/Physical Exam (90 min.) $200

I have reviewed the notice of Practice Guidelines and Patient Financial Policies from Lonna Larsh, MD/ Amber Weiss, PA-C. I hereby give my consent for the policies outlined above. If I do not sign this consent, or later revoke it, Lonna Larsh, MD or Amber Weiss, PA-C may decline to provide treatment to me.

_____ _____
Patient Name Date of Birth

_____ _____
Guardian Name Relationship

_____ _____
Patient/Guardian Signature Date

Patient Communication Authorization

Patient's Name: _____ Date of Birth: _____

Lonna Larsh, MD and Amber Weiss, PA-C use e-mail extensively for communication. You authorize the use of email to contact you for the following matters:
Appointment confirmation and reminders ___yes ___ no
Discussion of confidential protected health information, including notification and discussion of test results ___yes ___no

Preferred email address: _____
You will be automatically enrolled in our patient portal, enabling you to access to parts of your medical record online if you choose. If you don't want to any access to your records online, please let us know in writing.

When contacting you by phone to discuss health concerns, test results, or give appointment reminders, it's okay to call:

____Home phone number: ( )_____ Leave a message: __ yes __no

____Mobile number: ( )_____ Leave a message: __ yes __no Text: __ yes __ no

____Work phone number: ( )_____ Leave a message: __yes __no

____Call only this number: ( ) _____ Leave a message: __yes __no

It's ok to leave a message with family members ___yes ___no

If we need to reach you by mail, what is your best mailing address:

Street_____ Apt/Ste:_____

City_____ Zip Code _____ State _____

In case of emergency, please notify:

Name: _____ Best phone number: _____

I give permission to the individual(s) listed below to receive protected health information:

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_____ Date_____

Lab Testing Policy

Roots Of Health
Lonna Larsh, MD
Amber Weiss, PA-C, LAc
709 Frederick St.
Santa Cruz, CA 95062

In our office, we have the following policies regarding lab testing.

___ 1. Payment: We require payment in advance for any specialty labs that we order that are not run through insurance. We work with a couple of labs that offer wholesale prices for a variety of standard labs (often 90% less than the usual LabCorp or Quest prices). If we order labs for you at the wholesale cost, those payments cannot be submitted to your insurance company for reimbursement.

__ 2. Abnormal results: If your results are normal, you will typically get an email or phone call from us letting you know your results are normal. If your results are abnormal, we will need to discuss them with you, either over the phone or in person for an appointment. Costs for this appointment varies based on how long we talk. See our website or the practice guidelines/financial policies (listed above) for our current fees.

If you do not hear from our office within three weeks of doing your lab work, please contact our office. Every effort to contact you with your lab results will be made, but it is ultimately your responsibility to contact us to be sure nothing "falls through the cracks".

I have reviewed the notice of Lab Testing Policy from Lonna Larsh, MD/Amber Weiss, PA-C. I hereby give my consent for the policies outlined above. If I do not sign this consent, or later revoke it, Lonna Larsh, MD or Amber Weiss, PA-C may decline to provide treatment to me.

_____ _____

Patient Name Date of Birth

_____ _____

Guardian Name Relationship

_____ _____

Patient/Guardian Signature Date

Acknowledgement of Receipt of the Notice of Privacy Practices

Roots Of Health
Lonna Larsh, MD
Amber Weiss, PA-C, LAc
709 Frederick St.
Santa Cruz, CA

I have reviewed the notice of Privacy Practices regarding my Protected Health Information from Lonna Larsh, MD/Amber Weiss, PA-C. I hereby give my consent for Amber Weiss, PA-C to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, the above listed medical providers or their representatives may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. Such items may include appointment reminders and calls pertaining to my clinical care, including laboratory results among others.

With this consent, Lonna Larsh, MD or Amber Weiss, PA-C may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, laboratory results and patient statements. Electronic mail may be used for these purposes as well.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Lonna Larsh, MD or Amber Weiss, PA-C may decline to provide treatment to me.

_____ _____
Patient Name Date of Birth

_____ _____
Guardian Name Relationship

_____ _____
Patient/Guardian Signature Date

Received by: _____ on _____
Lonna Larsh, MD Date
Amber Weiss, PA-C

Vaccination Policies*

*This form applies only to children who are not fully vaccinated or may choose to opt out of certain mandatory vaccines in the future. If your child is fully vaccinated and you plan to complete all future vaccines on schedule, then you can skip this page.

At our office, we encourage thoughtful and individualized decision-making around medical choices. We honor your decisions as parents and your right to informed consent. There are risks and benefits to every decision, so we ask that you honor our policy if you choose to skip some or all vaccinations for your child.

___ 1. **Responsibility**: If your child happens to come down with a disease for which vaccinations are available, we ask that you take full responsibility for that risk. Lonna Larsh, MD and Amber Weiss. PA-C would be held harmless in the event of such disease or long-term consequences of that illness.
__ 2. **Have a plan**: We request that you have a plan in place for if your child were to develop one of the various infectious diseases for which vaccines are available. That plan should include calling your current pediatrician's office and following their advice.

Current pediatrician: _____ Phone number: _____

Pediatrician address: _____

__ 3. **Parental agreement for medical exemptions**: We require that both parents agree regarding the decision to seek a medical exemption for vaccines. If one parent decides they are no longer supportive of their child having a medical exemption, you agree to contact our office to inform us of this decision. Should this happen we may rescind your child's exemption.

Your signature(s) below mean: We have reviewed the notice of Vaccine Exemption Policies from Lonna Larsh, MD/Amber Weiss, PA-C. We hereby give our consent for the policies outlined above. If we do not sign this consent, or later revoke it, Lonna Larsh, MD or Amber Weiss, PA-C may decline to provide treatment to our child.

_____ _____
Patient Name Date of Birth

_____ _____
Parent #1 Name Relationship

_____ _____
Parent #1 Signature Date

_____ _____
Parent #2 Name Relationship

_____ _____
Parent #2 Signature Date