



YOUR KEY TO NATURAL HEALTH AND VITALITY

Consent and Acknowledgement Forms

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IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- There is a 72-hour cancellation policy (please see cancellation policy in Practice Policies for Patients).
- As a courtesy, we call to confirm the appointment prior to your scheduled time; ultimately it is your responsibility to keep the scheduled appointment or reschedule.
- For uninsured (out of pocket) functional medicine patients (discounted rates if paid at time of service)
 - Initial 60-120 minute Evaluation: \$800
 - Follow-up appointments to review lab results, or treatment programs: 50-minutes/\$400 or 25-minutes/\$200.
 - Nutrition appointments (not yet available) are \$150.00 for 50-minutes and \$75.00 for 25-minutes.
 - Weight loss program
 - First visit: \$300.00
 - Follow up: \$150.00/month till goal weight is reached
 - Maintenance: \$100 per month
- Lab and supplements are additional. Labs may be billed to insurance

LAB TESTS

- After your initial or follow up consultations, lab tests and/or diagnostic tests may be ordered.
- Test recommendations and costs will be reviewed.
- Lab tests are performed "fasting", which means nothing except water 10 hours before your visit.
- Some lab tests take up to 6 weeks to be finalized. The results will be mailed or emailed to you when they are finalized.
- If your follow-up appointment was not booked at the time of your initial visit, then you should contact the office to schedule a follow-up appointment.

BILLING/INSURANCE

We accept major third party insurance as well as Medicare for our services. Unfortunately, most third party insurance, and indeed, Medicare does not pay for the expanded functional medicine services. Our charges are determined by type of service (functional vs. internal) and insurance status (insured vs. uninsured). Insured patients will be responsible for any co-pay co-insurance, and deductible. Our functional medicine services involve extended physician time and services which are not covered by insurance. We charge an access fee to access functional medicine services. The access fees are in addition to insurance payments, and allow us to continue to provide functional medicine services. Uninsured patients are required to pay for services at the time of service. We provide a discount to uninsured patients when payment is made in full at the time of service.

PRIMARY CARE PHYSICIAN

It is not necessary for Dr. Quayle to be your primary care physician in order to be seen for any of our services. We recommend that you have a primary care physician at home, especially if you are coming from out of town. Patients coming for pain management must have a primary care physician because you may need your narcotics in the early stages of the program. Dr. Quayle will not write any prescriptions for narcotics.

Patient Name and Signature

Date

MEDICARE PATIENTS MUST SIGN THIS

NOTICE OF POSSIBLE MEDICARE DENIAL

Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) (1) of Medicare Law. If a particular service is considered not acceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

MEDICARE NOTICE

Medicare considers some of Dr. Quaye's services to be educationally oriented towards prevention and nutrition (CPT codes 99381-99404 and diagnostic ICD-9 codes other than a disease or injury classifiable in categories 001-999). Medicare may not cover any part of your clinical work up, evaluation or treatment. You may bill your supplemental insurance once you receive the "denial of coverage" from Medicare for our services.

Dr. Quaye will be using a diagnostic and treatment system based on Functional Medicine principles as outlined by the Institute of Functional Medicine.

Functional Medicine is a science-based healthcare approach that assesses and treats underlying causes of illness through individually tailored therapies to restore health and improve function.

He will be acting as your consultant using these principles to help you understand your present condition and what alternatives are available to you to help to achieve your intentions for improved health.

Your signature below will function as the requirement by your insurance carrier for you to acknowledge that you understand that your work up here does not fall under the usual and customary therapy covered by reimbursement by the CMS (Medicare)

PATIENT ACKNOWLEDGEMENT

My physician, and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

Signature: _____

Date: _____

Print Name: _____

NOTICE OF NON-COVERED SERVICES

Many insurance companies will only pay for services determined to be reasonable and medically necessary under the insurance company's terms of coverage. If a particular service is considered not acceptable and unnecessary under the insurance company's standards, they will deny payment for those excluded services.

INSURANCE NOTICE

Some insurance companies consider some of Dr. Quaye's functional medicine services to be outside the scope of routine medical care, and oriented towards prevention and nutrition (CPT codes 99381-99404 and diagnostic ICD-10 codes other than a disease or injury classifiable in categories 001-999). Insurance may not cover any part of your clinical work up, evaluation or treatment. You may bill your supplemental insurance once you receive the "denial of coverage" from your insurance company for our services.

Dr. Quaye uses a diagnostic and treatment system based on functional medicine principles as outlined by the Institute of Functional Medicine (IFM). The functional medicine visit usually lasts longer than a regular office visit, because of the comprehensive assessments, and time to explain results and the complex set of issues our functional medicine patients have to deal with. We estimate that a new functional medicine visit should cost \$800 to \$1200 for an initial visit, and a return visit should cost \$400 to \$600. The majority of the time is spent educating patients about our tests, and addressing lifestyle issues. Insurance payments of \$100 to less than \$200 do not meet our costs. There are no CPT codes to cover the comprehensive services of functional medicine. We will bill your insurance company for a regular office visit (CPT codes 99201 to 99205, and 99212 to 99215). In addition, we charge you a fee to access our premium functional medicine services. The fee for a new functional medicine visit is \$350, and \$150 for a return visit. This provides you access to our premium functional medicine services and labs (including time taken for interpretation).

Dr. Quaye will be acting as your consultant using these principles to help you understand your present condition and what alternatives are available to you to help to achieve your intentions for improved health.

Your signature below will function as the requirement by your insurance carrier for you to acknowledge that you understand that your work up here may not fall under the usual and customary therapy covered by reimbursement by your insurance company.

PATIENT ACKNOWLEDGEMENT

Dr. Quaye, and/or staff have informed me, that he believes services provided will likely be denied by my insurance company for reasons stated above.

Today's payment: Functional medicine New patient access () \$350, Established access () \$150

Signature: _____ Date: _____

Patient Name: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Facility or Person: _____

Address: _____

Telephone Number: (_____) _____ - _____

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to Magnolia Health Care all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: Yes No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: Yes No

Genetic Testing: Yes No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state or federal laws that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Magnolia Health Care, its employees, agents, managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand that there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

Name: _____ DOB: _____

Please Print

Signature: _____ Date: _____

PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM

Information Released: _____ Date: _____

Medical Records Technician Name: _____

Signature: _____

Please send records to: Magnolia Health Care, Inc. 619 S. Dargan St, Florence SC 29501 • Fax (843) 799-1392

**INFORMED CONSENT REGARDING EMAIL OR INTERNET
USE OF PROTECTED HEALTH INFORMATION**

Magnolia Health Care provides patients the opportunity to communicate with their health care providers, and staff by email. Members have access to text messaging as well. Transmitting confidential health information by email or text, however, has a number of risks, both general and specific, that should be considered before using email.

1. Risks of email and text messaging:
 - a. General risks are the following: electronic messaging can be immediately broadcast worldwide and received by many intended and unintended recipients; recipients can forward messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress a message; email is easier to falsify than handwritten or signed documents, backup copies of email may exist even after documents; backup copies of messages may exist even after the sender or recipient has deleted his/her copy
 - b. Specific message risks are the following: messages containing information pertaining to diagnosis and /or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the messages; patients who send or receive electronic messages from their place of employments risk having their employer red their email or text message (if one is using a company provided email or phone).
2. It is the policy of Magnolia Health Care that all email messages sent or received which concern the diagnosis or treatment of a patient will be part of that patient’s protected personal health information and will treat such email messages or internet communications with the same degree of confidentiality as afforded to other portions of the protected personal health information. Magnolia Health Care will use reasonable means to protect the security and confidentiality of email or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of email or internet communication.
3. Patients must consent to the use of email for confidential medical information after having been informed of the above risks.

Consent to the use of email or text messaging includes agreement with the following conditions:

- a. All emails to or from patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, such as Magnolia Health Care physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to email messages contained in protected personal health information.
- b. Magnolia Health Care may forward electronic messages within the practice as necessary for diagnosis and treatment. Magnolia Health Care will not, however, forward the messages outside the practice without consent of the patient as required by law.
- c. Magnolia Health Care will endeavor to read electronic messages promptly but can provide no assurance that the recipient of a particular email will read the electronic message promptly. Therefore, these messages must not be used in a medical emergency.
- d. It is the responsibility of the sender to determine whether the intended recipient received the message and when the recipient will respond.
- e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, electronic messaging should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmissible or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse
- f. Magnolia Health Care cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the email or internet communication but Magnolia Health Care is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.
- g. If consent is given for the use of email, it is the responsibility of the patient's to inform Magnolia Health Care of any types of information you do not want to be sent by email.
- h. It is the responsibility of the patient to protect their password or other means of access to email sent or received from Magnolia Health Care to protect confidentiality. Magnolia Health Care is not liable for breaches of confidentiality caused by the patient.

Any further use of email initiated by the patient that discusses diagnosis or treatment constitutes informed consent to the foregoing.

I understand that my consent to the use of email may be withdrawn at any time by email or written communication to Magnolia Health Care.

I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all risks associated with the use of email.

Signature: _____

Date: _____

Name: _____

RESEARCH CONSENT AGREEMENT

Patient's Name: _____

Patient's Address: _____

THE STUDIES

You are being asked to provide your consent for Magnolia Health Care to use information from your medical records in research studies, the goal of which is to improve the practices of the functional medicine approach. No personal identifying information will be used in the study. The Principal Investigator of these research studies is Emmanuel Quaye, M.D. Research in this case include case reports, where your information may be reported in a publication.

If you consent to the use of your medical records in these research studies, your personal information will be kept confidential to the extent permitted by law and will not be released without your written permission except as described in this paragraph. In all study forms, you will be identified only by a randomly selected patient number. Your name will not be reported in any publication; only the data obtained as a result of the use of your medical records in these studies will be made public.

Your decision as to whether or not to consent to the use of your medical records is completely voluntary (of your free will). If you decide not to consent to the use of your medical records it will not affect the care you receive.

If you decide to consent to the use of your medical records in connection with these studies, you may withdraw consent at any time without affecting the care you receive. You should contact the Principal Investigator (Dr. Quaye) and let him know about your decision if you decide to withdraw consent.

AGREEMENT TO PARTICIPATE

I have read the description of the research studies and general conditions. Anything I did not understand was explained to me by: _____, any questions I had were answered by: _____ . I hereby give my consent to Magnolia Health Care to use my medical records as described herein in connections with the research studies described herein. I will receive a copy of this Consent Form.

Signature of Patient/Legal Representative

Date

Signature and Name of Person Obtaining Consent

Date

FUNCTIONAL MEDICINE LABORATORY TESTING INFORMED CONSENT

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

I have read and understand the above:

Signature

Date

Witness

Date

NUTRITION SUPPLEMENTATION EDUCATION PROGRAM

Dear patient:

We invite you to sign up for our Nutrition Supplementation Education Program (NSEP). NSEP is designed to make it easy for you to obtain the supplements Dr. Quaye prescribes for you on a monthly basis. When you sign up for the program, you will get a monthly shipment of the prescribed supplements automatically, unless you cancel. You may sign up for the program on this page.

At Magnolia Health Care, we use vitamins and supplements for almost all our functional medicine treatments. This is because these are the building blocks on which the body is built. We are aware of various studies that claim that vitamins do not have a health benefit. There are other studies that show health benefits. Our clinical experience confirms their benefits. As to why there are research studies showing that vitamins have no health benefits, we believe the reasons are many, and may include the quality of supplements among other things. To ensure that you get the best quality vitamins and supplements, and also to ensure that the supplements we recommend are available, we have created the Wellness Marketplace, our retail outlet, right here in our office.

When you purchase your supplements from Wellness Marketplace, you are assured of quality products. We obtain our products from manufacturers who sell their products for distribution through professional medical offices such as ours. These are designed for use in supporting and enhancing your health.

Benefits:

Signing up for the program allows you to get a monthly shipment of your supplements without interruption. In addition to receiving your supplements on a monthly schedule, you will get a 5% discount. You will receive periodic information about any specials we may have. You may email any questions or concerns you have about your supplements, and often get a response within 24 hours.

Please read our brochure on “Why We Sell Nutraceuticals.”

IMPORTANT!

All information presented in this consent is intended for informational purposes only and not for the purpose of rendering medical advice. Statements made regarding any supplements and vitamins have not been evaluated by the Food and Drug Administration. The information contained herein is not intended to diagnose, treat, cure or prevent any disease.

This document is not a legal contract or agreement. Signing this page does not commit you to purchase any products in any amount from Magnolia Health Care or Wellness Marketplace. This document will be used to identify persons who indicate interest in our Nutrition Supplementation Education Program.

Consent

I _____ agree to sign up for Magnolia Health Care’s Nutrition Supplementation Education Program (NSEP). I understand that once my doctor has prescribed supplements, the supplements will be filled through the Wellness Marketplace. Shipment will be made only after I agree to terms, and after I receive the first shipment, I will continue to receive monthly shipments unless I cancel my membership in the program.

Signature: _____ Date: _____