Office: 702 S. Main St. , Cottonwood, AZ 86326

Phone: 928-649-0269 FAX: 866-644-6363

Email: office@breakthroughmed.com
Website: www.breakthrough-medicine.com

PATIENT INFORMATION & INFORMED CONSENT 2017 | 2018

I, _____ (please print), am seeking medical health care services from Dr. Shaida Sina

Please circle the follow that applies to your needs:

MEDICAL CONSULTANT *PRIMARY CARE*

Name of Primary Care Physician: _____

I understand that if I want Dr. Sina to work with me in a primary care capacity, she will require the following: annual labs and annual physical exam. I am aware that Dr. Sina is not a hospitalist nor does she have hospital privileges, and she is unable to provide emergency care. If I require emergency care, I should call 911 or go to the nearest emergency room or urgent care in your area. **If I choose to utilize Dr. Sina's services as a medical consultant, I will be required to have another provider do my physical exam annually per recommendation and progress notes forwarded for her for review. I am responsible for submitting all records.**

_____Initials

The office communicates via phone, fax, and email. If this is not acceptable I will let the front office know of my preferred means of communication. If I have a change in information for contact, it is my responsibility to inform the office. I understand that emailing or texting health issues is not an efficient way to contact and resolve issues. I also understand that **Dr. Sina cannot diagnosis or treat based on an email.** To receive health care treatment or report an adverse side effect, I understand and agree to call office and if recommended by staff, schedule a time to speak to the doctor or have an office visit.

_____Initials

Breakthrough Medicine Integrative and Longevity Center utilizes both conventional and alternative medical practices. I understand that in certain cases natural treatment or alternative assessment will not be sufficient treat or assess my condition. If I refuse traditional medical recommendation, and choose purely alternative therapy and my condition does not improve or gets worse, I will not hold Dr. Sina or Breakthrough Medicine liable. I understand with any treatment (alternative or conventional) the potential side effects such as but not limited to: Bruising, Allergic Reaction, Fainting, Infection, Burns, Cardiac Symptoms Scars, worst case scenario up to seizures, coma and/or death. I understand the risks vs benefits and will not hold Dr. Sina or Breakthrough medicine liable. Dr. Sina does not carry medical malpractice.

_____Initials

Breakthrough Medicine has a small in-office pharmacy for my convenience. I am in no way obligated to purchase the products recommended by staff or physicians at Breakthrough Medicine. I am free to purchase these products from any source that I may choose. I also understand the there is a no return policy.

_____Initials

The office cannot track patient orders such as labs. If given a recommendation for testing (blood work, radiology etc.) **it is my responsibility to remember to have my lab done.** If I do not hear back from our office, this does not mean your result is normal. I will need to call the office to see if the result has arrived, or contact the lab directly.

_____Initials

I understand that most health care insurance does not cover complementary and alternative medicine; therefore, I agree to pay at the time of service and/or when products are purchased. I understand that if I want Dr. Sina to fill out her section of the insurance claim form, I must ask for it at time of visit or risk adding additional time charges for Dr. Sina to go back into my medical chart to write up diagnosis codes. I also understand and do not hold Dr. Sina or Breakthrough Medicine liable if insurance does not reimburse for the visit or cover labs.

_____Initials

I understand that Breakthrough Medicine accepts cash, Visa & Master Card, and Checks. If I choose to use a check and the funds do not go through, I agree to pay with a different form of tender and pay the return check fee of $50 to compensate for lost office income, penalties, and extra stress within one week of being informed.

_____Initials

Dr. Sina charges for <u>all</u> the time spent on patient care. This includes time to review my chart and labs, writing prescriptions, researching special treatments or supplements, phone calls, text messages etc. Therefore, the time I'll be charged may be <u>more</u> than the time spent face-to-face with her. Dr. Sina has an ethical and legal responsibility to discuss the issues I bring up during your appointment. If you've only budgeted for a certain number of minutes, it's my responsibility to bring the appointment to an end.

_____Initials

When I make an appointment, this time is reserved for me. If I am unable to keep my appointment I need to give Dr. Sina at least 24 hours' notice or a $50.00 cancellation fee will be charged to me.

_____Initials

Release of Records Request has had Administrative fee of $25. If a medical chart is great than 10 pages, I will be charged an additional $0.10 per page and cost of postage.

_____Initials

Patient's Name (print): _____

Patient's Signature: _____

Date: _____