Agreement Form

Dr. Diane Grise
Phone: 602-551-7055

What to expect

- Dr. Grise is happy to offer both phone consults and in-office consultations.
- Your new patient consultation may be one visit or separated into two separate visits, time depending.
    - The new patient consultation typically lasts 3 hours, and consists of the following:
        - A full medical and homeopathic consultation
        - Physical screening examination
        - Review of records and ordering of additional necessary laboratory work
        - Analysis of laboratory work
        - Treatment planning for short term and long term goals
- After initiating treatment we offer one free, 5-10 minute phone check-in within the first month of treatment. This is a complimentary service, offered to clarify any questions you have from your initial visit.
- Follow up appointments will be scheduled based on your particular needs. However, patients are often scheduled for monthly follow up visits, with additional visits scheduled "as needed." For example, if you are being treated for an acute illness you may need to see your doctor more frequently.

Policies and Procedures

- **Setting up an appointment:**
    - If you need to speak to your physician or if you would like to set up a visit, please call the office at: 602-551-7055 or email at info@drdianegrise.com.
    - Subsequent follow up visits do not require an advanced booking deposit.
- **Cancellation Policy:**
    - **All cancellations or rescheduling must be done over the phone**
    - **New Patient Appointments:** Dr. Grise has a very busy practice and appointments may book out weeks to months. New patient visits require our doctors to block out large time slots making last-minute cancellations and rescheduling of visits very problematic. Dr. Grise spends a significant amount of time and energy with each of her new patients because of her commitment to providing the highest quality of medical and psychiatric care.
        - Cancellations or rescheduling of New Patient appointments must be done **48 week day hours** before the scheduled appointment, except in true emergency situations. For example if your appointment is on Monday, the cancellation call must be done by Thursday.
        - Cancellations and rescheduling for Monday appointments **must be done before 5:00 pm on Thursday**.
        - **A fee of $50 will be charged for late new patient cancellations.**
    - Existing Patient Appointments:

        - Follow up appointment cancellations must be done 24 hours before the day and time of your appointment. If you cancel after this time, e.g.: on the same day as your follow up, or no-show for your follow up, without a legitimate emergency reason, your credit card will automatically be charged the cost of the follow-up appointment.
        - _____ **(initials) I understand that if I need to cancel or reschedule an appointment that there may be fees as mentioned above.**
- **Phone policy:**
    - Phone consultations will be billed the same as in office consultations. Billing is based on expertise required on the part of the physician, and phone consultations require the same amount of time and expertise as in-office visits.
    - If you need to speak with your doctor please call the office to schedule an appointment by calling the office number.
    - _____ **(initials) I give my consent to voice messages being left at the phone number I provided. I understand that there is no guarantee that phone messages are private and that voice mail is not protected by HIPAA.**
- **Emergency calls**: Dr. Grise is not equipped to do emergency triage. If you are experiencing a psychiatric emergency please call the Maricopa crisis line, call 911 or go to the nearest emergency room or urgent care clinic.
    - _____ **(initials) I understand in the case of psychological crisis I will immediately call the Maricopa Crisis Hotline at 602-222-9444 or the National Suicide Hotline at 1-800-273-8255.**
    - _____ **(initials) I understand that in the case of a life threatening psychiatric or medical emergency that I will call 911, or go to the nearest emergency room.**
- **Email policy:** Email is not a secure form of communication and therefore Dr. Grise will only use email **as a means for sending forms and documents**. Dr. Grise will not be responsible for material in, reading of, or responding to emails.
    - _____ **(initials) I understand emailing is not a secure form of communication, and I understand that by emailing Dr. Grise that there is a chance that my private information is at risk.**
    - _____ **(initials) I understand that Dr. Grise is not responsible for reading or responding to my emails, and is not responsible for any information in any emails.**
- **Texting policy:** Dr. Grise does not use text messaging to communicate medical advice, except in urgent situations where a phone conversation is not possible. Text messaging is not the most secure or reliable form of communication. Dr. Grise is not responsible for receiving, reading or responding to any text messaging. Please call the doctor rather than texting.
    - _____ **(initials) I understand that Dr. Grise is not responsible for receiving, or responding to any text messages.**
    - _____ **(initials) I understand texting is not a secure form of communication and I understand that by attempting to text Dr. Grise that there is a chance that my private information is at risk, and therefore Dr. Grise is not liable for any compromised information that occurs as a result of text messages sent.**

Appointment types

- **Follow Up Appointments**

- A follow up appointment is intended for following up on treatment, assessing any new symptoms, changes in symptoms, and adjusting treatment protocols; including supplement dosages, types, brands, homeopathic medicines, doses, writing/calling in prescriptions, and providing clinical information regarding care, laboratory work, and other issues as they pertain to patient care. For any new symptoms that arise, or any additional questions or concerns, please call our office to be scheduled for a follow up visit. Moreover, if you are not responding to your protocol, or need additional treatments for your symptoms, a follow up visit is recommended.

- **Check-in Appointments**
  - The purpose of a check in is to ensure that you are doing well on a protocol, or for you to clarify a previous recommendation, for example: If you were instructed to a particular medicine and you want to be sure you have the correct dosing. Any questions that exceed will be best addressed during a follow up visit.

Fees and Services
(Visit Duration and Prices Subject to Change)
Part 1-New Patient Medical Intake: $200 (2 hours)
Part 2-Homeopathic Medical Intake: $150 (1.5 hours)
Follow up: $100 (30 minutes)
Phone check-in 5 minutes or less: $25
Phone check-ins up to 15 minutes: $45

Payment Policies:
- Payment is due at time of service.
- Payment may be accepted in the form of cash, check, credit card and some health savings account cards.
- Any fees accrued by bounced checks will be paid for by the patient, and Dr. Grise has the right to refuse to accept checks as a form of payment in future visits. An additional fee of $12 per day will accrue until the final balance is due is paid off post bounced check.
- New patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment.
- A non-refundable deposit of $100 will be required for booking your New Patient consultation. This balance may be applied to your New Patient visit cost (except in the circumstances delineated in the cancellation/rescheduling section of this agreement).
- There are no refunds for any services.

Insurance
- This office is "cash pay" only and does not offer services to submit to your office visits to insurance, however upon request, we will provide you with a form so that you may submit to your insurance.
- Dr. Grise cannot guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs and imaging studies. You are ultimately responsible for the cost of your care at our office.

Payment method: Check, Cash, PayPal, Credit Cards, & Health Savings Account Cards

Advance Beneficiary Notice (ABN): I understand that my insurance will not be paying for any of the fees for my visits, labs, medications, or supplements under the care of Dr. Grise. I understand that I am solely responsible for paying all of balances, fees, and services accrued with the aforementioned payment methods only.

- _____**(initials)**

Privacy, Rights, Responsibilities, and Liabilities

Below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can acquire a full listing and explanation of your rights and privacy practices by going to the website at http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

You have the right to:

- Receive a notice that tells you how your health information may be used or shared.
- Ask to see and obtain a copy of your health records.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Have corrections added to your health information.
- Request where you would like to be contacted.
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with the U.S. Government.
- File a complaint with your doctor.

The following is to be signed by the patient, or the person legally responsible for the patient's medical decisions relative to the treatment situation.

I, (print name) _____ (sign name) _____, hereby acknowledge that the office of Dr. Grise provided me with access to Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact: **http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.** By signing this I also acknowledge that I understand that I am entitled to receive updates upon request if the office of Dr.Grise amends or changes their Notice of Privacy Practices in a material way.

Dr. Grise will respect your rights to privacy. However if it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, Dr. Grise has the obligation to disclose any relevant information.

_____ **(initials) I understand that Dr. Grise may disclose private information in circumstances where there is a threat to my health or safety, or the health and safety of another individual or public. Therefore I do not hold liable this doctor for disclosing private information in these circumstances.**

Additionally, with the objective of personalizing and coordinating my care with other practitioners, Dr. Grise is authorized to discuss my personal medical information with the following people:

1) _____ (phone) _____
2) _____ (phone) _____
3) _____ (phone) _____

_____ **(initials) I understand that by providing the aforementioned contacts I am authorizing my doctor to correspond with the contacts above regarding my heath care.**

My "in case of emergency" contact is:

1) _____ (phone) _____
2) _____ (phone) _____

_____ **(initials) I am entitled to receive high quality naturopathic medical care provided by Dr. Grise. Be informed that if your doctor needs to that she will consult with other physicians and specialists to provide you the most quality care possible, while being compliant to HIPAA requirements.**

_____ **(initials) I understand that Dr. Grise does not discriminate based on age, gender, race, ethnicity, socioeconomic status, religion, sexual orientation, or other lifestyle or cultural preferences.**

_____ **(initials) I understand that naturopathic medical treatments and therapies may be different from those offered by other licensed health care providers and that I am at liberty to seek other care. However if I do choose to seek other treatment in addition to my care with Dr. Grise, I will inform my doctor of any other treatments I am using as they may affect my care.**

_____ **(initials) I understand that payment is expected at the time of service, and I will pay in either cash, check or credit card based on the rates listed above. Failure to pay at the time of service will accrue late fees of $15 per day.**

_____ **(initials) I understand that Dr. Grise is treating me for my chief concern, based on the symptoms that I report, and/or lab-work that is ordered by Dr. Grise. Therefore I hold Dr. Grise blameless if there is a condition that I have or develop that I did not report symptoms of, a history leading to, or concerns about. Such a condition therefore would be considered outside of my care with Dr. Grise.**

_____ **(initials) I understand that if at any time I have a plan to hurt myself, or become suicidal or homicidal I will immediately do the following:**

- **Call 911 or**
- **Call The NATIONAL SUICIDE HOTLINE NUMBER at 1-800-273-8255 or**
- **For Maricopa County residents: Call The MARICOPA CRISIS LINE NUMBER at 602-222-9444**

By signing this agreement you are indicating that you understand and agree to the terms of service explained above. You also indicate understanding of the Rights, Responsibilities and Liabilities section explained above. By signing this agreement, you also indicate that you have given your permission to the office of Dr. Diane Grise to automatically charge your credit card for missed appointments, phone consultations, or any of the above stipulations that may apply to you. You retain the right to request phone consults or other services to be paid with another card or account at the time of service. By signing this agreement you indicate that you understand the appropriate steps to take in an emergency situation and you agree to the terms set above.

Name of Patient or Legal Guardian: _____

Signature: _____ Date: _____