TENPENNY

INTEGRATIVE MEDICAL CENTER

Welcome! And thank you for choosing Tenpenny Integrative Medical Center as part of your journey to optimal health.

Financial Information:
Payment in full is due at the time of service. We accept cash, check, and most major credit cards.

While we do not participate with any insurance company directly, we do participate with CareCredit and most HSA plans. At the time of your visit, you will be given a HCFA form as a receipt for your services; you can submit this form to your insurance carrier for possible reimbursement. The amount of reimbursement will vary based on the amount of out-of-network coverage your plan provides and if you have met your out-of-network deductible. **HCFA FORMS CANNOT BE SUBMITTED TO MEDICARE OR MEDICAID.**

We do not participate with Medicare, but we offer a Private Contract option. We do not participate with Medicaid, CHIPS or military insurance programs.

Our goal is to identify the underlying cause(s) that lead to your current condition using unique testing and assessments. Many of our specialized tests are not covered by medical insurance. Most of the laboratories we use require a co-payment to be sent, with your blood samples, directly to the laboratory.

Tenpenny Integrative Medical Center receives no remuneration for tests ordered through Spectracell, Quest, DoctorsData, Cyrex, Boston Heart or other in-house kits or laboratories we use. If you order tests using our DirectLabs.com affiliate link, the program pays a 5% commission on all tests ordered with our link. All laboratory tests require a fee which is separate from office visit charges.

PLEASE ARRIVE AT LEAST 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT *WITH YOUR FORMS COMPLETED*.

Completed forms are very important for your assessment. If the forms are not with you or are not completed prior to your scheduled appointment, it may be necessary to reschedule your appointment and enforce our cancellation policy to respect the time of other patients scheduled after your appointment.

Please Initial _____

HOW DID YOU HEAR ABOUT US?

Please help us know how to best reach others. Mark all that apply.

- ☐ Patient referral: _____
- ☐ Physicians referral:_____
- ☐ Tenpenny Integrative Medical Center website
- ☐ DrTenpenny.com website
- ☐ Other website _____
- ☐ Westlake Magazine
- ☐ Berea Community Guide
- ☐ Our eNewsletter
- ☐ Direct mail marketing piece

- ☐ Radio show _____
- ☐ TV show _____

Social Media Referral

- ☐ Facebook
- ☐ Twitter
- ☐ YouTube video
- ☐ Other: _____

WHO ARE YOU SEEING TODAY?

☐ Sherri Tenpenny, DO	☐ Matthew Grant, DC
☐ Janet Levatin, MD	☐ Sandi Asazawa, PA
☐ Autumn Schaef, NP	☐ Thermographer
☐ Blake Hardy, NP	☐ other ---

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AUTHORIZATION & ACKNOWLEDGEMENTS

☐ INITIAL ☐ ANNUAL UPDATE

TREATMENT AUTHORIZATION: I (print name) _____ authorize medical treatment of myself or my minor child by physicians, nurse practitioners, physician assistants, nurses, chiropractors, acupuncturists and medical assistants and staff by OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center.

NOTICE AS TO NATURE OF SERVICES: I understand that the care I receive at OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine, or innovative services. Many of these services may not be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my physician may request laboratory testing which may include venipuncture, analysis of stool, urine, saliva and breath.

NOTICE THAT SERVICES ARE NOT PRIMARY CARE: I understand that no physician or any other practitioner I see at OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center is acting as my primary care physician unless otherwise agreed to by a physician in writing. As such, emergency services are not offered. I understand that even though my physician(s) and OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a hospital based pediatrician if I am seeking treatment for my children. I also understand that it is my responsibility to inform OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center in order to properly and safely coordinate my care. My primary care physician is:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

I am also being treated for _____ by:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL OSTEOMEDII, INC D/B/A TENPENNY INTEGRATIVE MEDICAL CENTER SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit, unless other specific arrangements have been made. I am responsible for charges incurred for all treatment rendered, unless otherwise agreed to in writing. I further understand OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center to take action to secure payment of an outstanding balance owed.

Patient Name: _____ Date: _____

CANCELLATION AND/OR NO-SHOW POLICY: OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center urges you to keep every appointment, as consistent treatment is essential to journey to wellness. In the event you need to cancel an appointment, we require no less than two (2) business day notice, (48 hours) excluding Saturday and Sunday. ***Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a charge of $225.00 for a New Patient Appointment and $98.00 for a Follow Up Appointment.***

Initials:_____

NOTICE TO MEDICARE PATIENTS: The physcians at OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center**.** I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said services(s).

CLAIM MANAGEMENT: My treating practitioner(s) may respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information. Insurance claim forms and information will be provided to patients at the time of visit or sent to you upon the availability of the appropriate documentation. OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center does not typically send information directly to insurance carriers due to problems we have experienced with carriers misplacing claims.

FURTHER NOTICES AS TO POLICIES REGARDING INSURANCE: OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center will provide claim forms for submission to insurance; submission shall be the patient's responsibility. Claim submissions may or may not be for covered services and may or may not include procedural codes or other data sufficient to support my insurer's determination as to what services it will reimburse. OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center may provide records requested by my insurance company. If possible, OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, OsteoMed II, Inc D/B/A Tenpenny Integrative Medical Center cannot be responsible for any information that turns out to be incorrect.

NO GUARANTEES: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at OsteoMedII, Inc d/b/a Tenpenny Integrative Medical Center.

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form, I acknowledge that I have received a copy of OsteoMedII, Inc d/b/a Tenpenny Integrative Medical Center Authorizations and Acknowledgements.

Patient's Signature:	Date:
Witness's Signature	Date:

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INTEGRATIVE MEDICAL CENTER

7380 ENGLE ROAD
MIDDLEBURG HEIGHTS, OHIO 44130
440.239.3438

CANCELLATION POLICY

In the event you must cancel and/or reschedule your first appointment, we require a minimum notice of two days, excluding Saturdays and Sundays. Patients who cancel without proper notice or **fail to show** for the scheduled appointment will be subject to **a $225 charge**.

We also require two-day notice to cancel a follow up visit. If an appointment is cancelled without proper notice or if you **fail to show,** you will be subject to a **$98 charge.**

We understand that sometimes emergencies arrive on short notice. If the **new appointment** is rescheduled and completed within five (5) days of the missed appointment, $150 of the cancellation charge will be applied towards the completed visit. If a **follow up appointment** is rescheduled and completed within five (5) days of the missed appointment, $75 of the cancellation charge will be applied towards the completed follow up visit.

When you schedule an appointment, we hold this space for you. To be fair to our business and to other patients who could have been seen during that time, our cancellation policy will be strictly enforced.

We appreciate your understanding and respect of our policy.

I have read and agree to adhere to this policy

Signature:_____

Date: _____

Last Name			DATE
First Name			DOB
Address			Age ☐ MALE ☐ FEMALE
City	**State**	**Zip**	
HOME TELEPHONE:	**WORK TELEPHONE:**	**MOBILE PHONE**	
☐ Use this number as my primary contact	☐ Use this number as my primary contact	☐ Use this number as my primary contact	
☐ OK to leave detailed message	☐ OK to leave detailed message	☐ OK to leave detailed message	
☐ Leave your name and call back number only	☐ Leave your name and call back number only	☐ Leave your name and call back number only	
Email address:	**May be add your email to our in-office email databaseand Constant Contact mailing list? ☐ YES ☐ NO**	**WE PROTECT YOUR EMAIL PRIVACY AND IS USE FOR IN-OFFICE ALERTS AND PROMOTIONS ONLY.**	
EMERGENCY CONTACT NAME	EMERGENCY CONTACT NUMBER	RELATIONSHIP:	

CREDIT CARD PAYMENT AUTHORIZATION

I, _____, hereby authorized Tenpenny Integrative Medical Center and/or the office staff from 7380 Engle Road, Middleburg Heights Ohio 44130 to charge my credit card for products purchased and/or services rendered including missed office visits, as outlined by the Tenpenny Integrative Medical Center office policy. This authorization will remain in effect indefinitely; I reserve the right to cancel this authorization at any time. It is my responsibility to notify Tenpenny Integrative Medical Center of any changes regarding this credit card authorization, including change of numbers, expiration dates, etc. My signature below confirms I understand and agree to this authorization.

NAME ON CARD		**CARD NUMBER:**
CREDIT CARD TYPE: ☐ MASTERCARD ☐ VISA ☐ DISCOVER		**SIGNATURE AND DATE:**
EXP. DATE:	CVV CODE:	
BILLING ZIP CODE:		

INSURANCE INFORMATION

Insurance Company:	
Address:	City, State and zip
Insurance ID number	Group Number
Insurance Policy Holder	Policy holder date of birth:

I give my permission to share my medical information with _____

My relationship to this person is _____

I attest to the best of my knowledge, the information above is true and accurate.

Signature:	**Date:**