Dr Robin A. Bernhoft, MD

FOR CHRONIC ILLNESS & ALLERGY

CONSENT FORMS

1200 Maricopa Highway, Suite A
Ojai, CA 93023

Phone (805) 640-0180
Fax (805) 640-0181

www.drbernhoft.com
info@drbernhoft.com

PATIENT PLEDGE

Your health and healing depend on our commitment to doing the best we can and your commitment to:

- ***The Bernhoft Approach***
  We strongly recommend that you fully commit to the medical approach of Dr. Bernhoft in order to succeed. Working with multiple centers or physicians, other than your primary care physician, may create contradiction, confusion and frustration – ultimately delaying your progress.
- ***A Partnership and a Process***
  Some chronic illnesses can take weeks, months or even longer to improve. If you don't see immediate results, don't give up. With Dr. Bernhoft, healing is based on a partnership and a process. It takes time, patience and persistence to find and treat the root causes of your illness. You will have to work hard, and so will we.
- ***Prescribed Changes***
  Your commitment to comply with prescribed dietary changes, supplements, and medications, as well as other treatment recommendations, is the key to healing. If you don't follow the plan with reasonable consistency, your progress will likely be stalled.
- ***Patient / Physician Commitment***
  Establishing and maintaining a good working relationship with Dr. Bernhoft is a key element in your success. Once treatment is initiated with Dr. Bernhoft, it is important that you remain in his care and stay in regular communication with us.
- ***Ongoing Support***
  Functional medicine is a different approach from the existing health care model. Chronic illness can contribute to challenges with focus, cognition, energy and mood. Some of the changes that we ask of you may feel overwhelming at times. We urge every patient to find support at home. Family or friends may provide support, but that is not always adequate. If you need our help, call us.

I have read and agree to the statements above.

_____

Please Print Your Name Date

_____

Patient Signature

IMPORTANT PATIENT INFORMATION

APPOINTMENTS

- There is a 72-hour cancellation policy for your first Initial appointment.
- There is a 24-hour cancellation policy for all follow-up appointments.
- As a courtesy, our system sends you automatic appointment confirmations prior to your scheduled time; it is your responsibility to keep the scheduled appointment or reschedule. Fees will apply to missed appointments.

LAB TESTS

- After your initial and follow-up consultations, lab tests and/or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- If a test is billed through insurance, it is the patient's responsibility to pay the remaining cost. Patients concerned about costs can call their insurance *prior* to testing.
- Some lab tests take up to 6 weeks to be finalized. When all lab results are in, the office will contact you to set up your follow-up.

BILLING/INSURANCE

- Payment for the office visit, phone consultation or lab tests is expected at time of service. We accept cash, check, credit cards or Care Credit. Ask front office about Care Credit if you are not a member currently, or apply at CareCredit.com. All credit card payments will be processed the same day of the visit or phone call.
- The Medical Office of Robin A. Bernhoft, M.D. does not participate with any insurance carrier. We do not submit medical claims on your behalf and we cannot assist you with claim resolution. All services are strictly on a self-pay basis; however we will provide you with a detailed billing summary that you may submit to your insurance carrier for possible reimbursement. Please note that there may be procedures and laboratory tests that are non-covered due to your individual policy/plan type. Should you have any questions regarding your medical coverage, please call the telephone number on the back of your insurance card.
- The Medical Office of Robin A. Bernhoft, M.D. does not participate in the Medicare program. If you are a Medicare Part B beneficiary and wish to become a patient of the Center, you are required to accept the terms and conditions set forth in a Private Contract between you and Dr. Bernhoft. This Private Contract provides that absolutely no Medicare payment will be made to you or to Dr. Bernhoft for the services provided, even if said services are allowed coverage by Medicare. Under the Private Contract, you acknowledge that you accept full responsibility for the payment of charges for all services rendered by Dr. Bernhoft; such payments are due in full at the time of service.

MEDICARE PRIVATE CONTRACT

(For Medicare Patients Only)

(In compliance with 42 U.S.C. 1395a; 42 C.F.R. 405, subpart D)

This contract is entered into by and between Robin A. Bernhoft, M.D. (hereinafter called "physician"), whose principal medical office is located at **1200 Maricopa Highway, Suite A, Ojai, CA 93023 and 2128 Pico Blvd., Santa Monica, CA 90405** and _____(hereinafter called "beneficiary"),
(Patient Name)
who resides at_____, and shall become effective on this____day of
(Address) (Current Day)

_____, 20_____, in accordance with the 42 U.S.C. 1395a; 42 C.F.R. 405, Subpart D.
(Month and year)

PHYSICIAN OBLIGATIONS
The physician acknowledges that he is excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The physician acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. 405.440.

The physician acknowledges that he must retain this contract (with original signatures of both parties to this contract) for the duration of the opt-out period, and that it shall be made available to the Centers for Medicare & Medicaid Services (CMS) upon request.

The physician shall provide this original or a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician acknowledges that he must enter into a contract for each opt-out period.

BENEFICIARY OBLIGATIONS
The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understand that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what

MEDICARE PRIVATE CONTRACT

(continued)
the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare. The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare covered items and services from physicians and practitioners who have not opted out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.

The beneficiary, or his or her legal representative, understands that Medicare plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

I understand that during the opt-out period, a Medicare Advantage plan may not by law make any payments to the physician for any Medicare items and services furnished to the beneficiary under this contract.

Robin A. Bernhoft, M.D.
1200 Maricopa Hwy, Ste A
Ojai, CA 93023 805-640-0180

Date

Printed Name of Beneficiary (printed) or Legal Representative

Signature of Beneficiary or Legal Representative

Date

Home Address

Telephone Number

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

You should use this form to submit to your Physician's office to release records to Dr. Robin A. Bernhoft, M.D.

Name of Facility or Person:

_____

Address:

_____

Telephone Number: ( ) _____ –_____ Fax Number: ( )_____– _____

THE PURPOSE FOR THIS RELEASE:

You are hereby authorized to furnish and release to *Dr. Robin A. Bernhoft, M.D.* 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 *Dr. Robin A. Bernhoft, M.D.,* 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.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(continued)

***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:

Dr. Robin A. Bernhoft, M.D.,
1200 Maricopa Highway, Suite A, Ojai, CA 93023
Fax 805-640-0181

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

The medical office of Dr. Robin A. Bernhoft, M.D. ("RABMD") provides patients the opportunity to communicate with their physicians, health care providers, and administrative staff by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten or signed documents; backup copies of email may exist even after the sender or the recipient has deleted his/her copy.

   b. Specific e-mail risks are the following: e-mail 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 e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of RABMD that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that patient's protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. RABMD will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail or internet communication.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

   a. All e-mails 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 RABMD physicians, nurses, other health care practitioners, insurance coordinators and upon written authorization other health care providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. RABMD may forward e-mail messages within the practice as necessary for diagnosis and treatment. RABMD will not, however, forward the email outside the practice without the consent of the patient as required by law.
   c. RABMD will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail 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. RABMD cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail or internet communication but the office of RABMD 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 e-mail, it is the responsibility of the patient's to inform RABMD of any types of information you do not want to be sent by e-mail.
h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from RABMD to protect confidentiality. RABMD is not liable for breaches of confidentiality caused by the patient.

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

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to RABMD.

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

Name: _____ Date: _____

Signature: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ Date: _____
Robin A. Bernhoft, M.D.

_____ Date: _____
Signature of Patient or Guardian

_____
Print Name of Patient or Guardian

PLEASE NOTE:

Many of our patients are chemically sensitive.

We ask that you or *anyone* entering our office **wear no scented products—** Perfume, cologne, hair spray, fabric softeners, after-shave lotions, essential oils, etc.

You may be asked to reschedule your appointment if you arrive wearing scented products to keep our other patients safe.

Thank you for your cooperation.