Dear Friend:

Thank you for choosing The Healing way Chicago! Below are some instructions to assist you with preparing for your first appointment.

New Patient Checklist

- ☐ Read over the following documents attached to this email: welcome letter from Dr. Singh and our financial policy explanation.
- ☐ Complete the attached written questionnaire and follow the attached instructions to complete your profile and new patient intake form in Practice Fusion, our electronic health record. Please complete the questionnaire and complete your online profile **1 week prior** to your appointment so that Dr. Singh can adequately prepare. Our email are located at the bottom of the questionnaire. *If you are not comfortable with computers give us a call and we will do our best to accommodate you.
- ☐ Complete the Credit Card Authorization so we may process your new patient deposit ($300)
- ☐ Read over and sign the consent form and permission for alternative testing form acknowledging that you have read, and agree with Dr. Singh's policies
- ☐ Complete the Authorization of Release, which releases applicable medical records to Dr. Singh. To have records available for your first appointment, we request that you fax this authorization to relevant health care providers. Dr. Singh will assess if additional records are needed during her initial meeting with you.
- ☐ On the day of their appointment, please bring any prescriptions or supplements you are taking.

What to Expect at Your First Appointment

Dr. Singh will spend 2 hours at your new patient visit. Please arrive 15 minutes before your scheduled time. You will find it refreshing how she talks to you as a person and not as a set of symptoms. Together you will explore all aspects of life that affect your health and well-being. The two of you will create a whole-person approach to your health care. We recommend that you continue to consult with a primary care physician in addition to the care you receive from Dr. Singh. The initial visit costs $800 ($500 is due at your appointment if have already paid your $300 deposit), and follow up visits are $350 for 60 minutes.

Insurance Reimbursement

While Dr. Singh does not accept insurance, we will provide you with a document that you can submit to your carrier for reimbursement at an out-of-network rate after you have met your deductible. This does not guarantee reimbursement so we recommend calling your carrier beforehand to find out what will or will not be reimbursed and if you need a referral from your primary care physician. IMPORTANT NOTE FOR MEDICARE PATIENTS: Dr. Singh now accepts Medicare patients, but due to their billing guidelines, appointments **cannot** be submitted for reimbursement.

TULIKA SINGH M.D.
INTEGRATIVE & FUNCTIONAL HEALTH CONSULTANT
6565 N AVONDALE AVE CHICAGO, IL 60631

773-250-1234 (EXT 0)
INFO@THEHEALINGWAYCHICAGO.COM
WWW.THEHEALINGWAYCHICAGO.COM

Cancelations

Due to the Dr. Singh's extensive patient preparation, we require a 3-business day notice for all appointments. If we do not receive a 3-day notice, cancelation fees are as follows: $300 fee for missed new patient appointments, $100 fee for missed follow-up appointments. If you provide the 3-day notice, full pre-payment will be refunded or applied to a rescheduled appointment.

We look forward to working with you!

Please fax the written questionnaire and complete your online profile **1 week prior** to your appointment.

Sincerely,

Tulika Singh, MD
Clinical Assistant Professor of Emergency Medicine, University of Illinois at Chicago
Fellow, University of Arizona Center for Integrative Medicine, Tucson

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AUTHORIZATIONS, ACKNOWLEDGMENTS & INFORMED CONSENT

Education, experience and credentials: Tulika Singh, MD is board certified in pediatrics and Emergency Medicine and is in the fellowship through the University of Arizona Program in Integrative Medicine. She is licensed by the State Board of Medicine to practice in Illinois and holds a faculty appointment at University of Illinois at Chicago as Clinical Assistant Professor of Emergency Medicine.

Treatment Authorization: I authorize medical and health care treatment of (circle one and insert applicable name):

Myself OR My Minor Child _____ by TULIKA SINGH, MD
(Please insert Your Name **OR** the Name of Your Minor Child)

Medical Records Release Authorization: I authorize Dr. Singh to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. I also authorize any physician or health care provider I have seen, to release my medical records to Dr. Singh. Such authorization is effective for a period of one year, and extends to records regarding my minor child, if applicable.

Privacy Statement: While Dr. Singh is not required to follow the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA) because she is a solo practitioner, she respects my privacy and will only release information required to further my treatment, assist me with insurance reimbursement, or if authorized by me. Additionally, I understand that communication will be primarily electronic via patient portal and email and accept the risks attendant to this.

Notice as to Possible Non-Coverage of Services: I understand that my insurance company may not reimburse me for services rendered. My insurance company may not pay for office visits where the focus of the consultation is on wellness, herbal medicine, or other complementary and integrative medicine (CIM) services. While most lab testing is covered by insurance, some lab tests, particularly those for wellness consultations or that use innovative technologies, may not be reimbursed. Dr. Singh will discuss all my laboratory testing options with me prior to ordering them.

Financial/Insurance Responsibility: I understand that Dr. Singh although fully credentialed by insurance carriers in the past, is now considered an out of network provider. I understand and agree that Dr. Singh does not take assignment, which means that payment will be required at each visit. To request reimbursement from insurance, I understand that I can submit my receipt and superbill (form with diagnostic codes) and that it is my responsibility to submit these claims to my insurer. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Singh to take action to secure payment of an outstanding balance owed.

Claim Management: I understand that it is my responsibility to know my plan benefits. Dr. Singh may offer some assistance, but given the uncertainty that pervades insurance decisions, she is not responsible for any information that turns out to be incorrect. Dr. Singh will 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.

No Guarantees: I am aware that no practice of medicine is an exact science, and acknowledge there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

Duration/Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

NOTICE THAT SERVICES ARE NOT PRIMARY CARE

I understand that Dr. Singh is not acting as my primary care physician. I understand that even though she may address issues affecting my general health, the practice is focused on a complementary, holistic or integrative approach to medicine. It is in my best interest to also have a primary care physician to ensure that I am fully informed about all available conventional means to address any medical conditions I may have. This is also important because Dr. Singh 's practice is exclusively office-based and is 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 Dr. Singh does not provide emergency, on-call assistance. Should Dr. Singh provide treatment for a condition, I understand this assistance does not mean she is taking primary responsibility for managing that condition, but is complementing the care I receive from my primary care physician. 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 pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility on an ongoing basis to inform Dr. Singh of the name of and contact information for my primary care physician and treating specialists, of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions. I also understand that it is important for me to let my primary care physician know about any recommendations/treatments performed by Dr. Singh in order to ensure that my care is properly coordinated.

Primary Care Physician Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Additional Care Information:

I am being treated for: _____

_____

By: _____

Phone: _____

I am also being treated for: _____

_____

By: _____

Phone: _____

I am also being treated for: _____

_____

By: _____

Phone: _____

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NOTICE AND CONSENT AS TO NATURE OF SERVICES, CONSENT TO RECEIVE TREATMENT

I understand that care I receive from Dr. Singh may be non-traditional or non-conventional. Such services are commonly referred to as complementary or alternative medicine (CAM), holistic care, or integrative medicine. This can include a variety of innovative medical treatments as well as nutritional and herbal consultation, and mind-body approaches to care. Many of these services may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, and have reasonable medical evidence, they may still be considered investigational or experimental. I am seeking care from Dr. Singh in order to benefit from her special training in integrative and functional medicine and receive advice and treatment about such care.

Nutritional and Herbal Guidance: Consultations may include discussion of diet, dietary supplements, and herbal or botanical products. While herbs and botanical products are generally available over-the-counter and considered safe based upon their long history of use, many have not been widely tested. Dr. Singh has been trained to prevent drug-herb and herb-herb interactions; however I understand that I am at risk, although unlikely, for an adverse reaction, reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will inform Dr. Singh and other physicians of what herbs I am taking. I agree to notify Dr. Singh if I experience any interactions or adverse experiences or reactions; if they are not serious I will notify her to ask for her assistance and if serious, I agree to seek emergency care first before notifying Dr. Singh.

Mind/Body Medicine: Because stress and emotional states may play an important role in my medical conditions, Dr. Singh may assist me in recognizing more successful approaches to lifestyle and mind/body approaches such as meditation, and other stress management techniques.

I have read and understand the nature of the services provided by Dr. Singh. I agree to take a responsible role in improving my own health and discuss advice and suggestions of Dr. Singh as presented in a treatment plan. I acknowledge that if I do not follow the treatment plan as provided, I may not receive the full benefit of the treatments proposed by Dr. Singh and I accept responsibility for less than satisfactory results.

I hereby certify that I understand the above authorizations and the risks of possible complications. I have been adequately informed, and questions I have asked have been satisfactorily answered. I represent that I am seeking diagnosis and treatment in order to further my own health and for no other reason. I am aware that I may withdraw this consent and stop treatment at any time.

I affirm by my signature below that I have read, understand and agree with the patient notices herein.

PRINTED Patient Name: _____

Patient Signature: _____

Date Signed: _____

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Authorization for the Release of Information

I, the patient, hereby authorize the use or disclosure of my health information from the practitioner below to Dr. Singh.

PATIENT INFORMATION

Name _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone _____ **Social Security #** _____

HEALTH PRACTITIONER – practitioner who has medical records that I would like Dr. Singh to have.

Practitioner Name _____

Address _____

City _____ **State** _____ **Zip Code** _____

Phone _____ **Fax** _____

I authorize the above named practitioner to release and/or disclose the medical information as indicated below to Dr. Singh.

Duration This authorization shall become effective immediately and shall remain in effect until the below or for 1 year from the date of signature in no date is entered. **DATE: / /**

Revocation This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Check the box and initial which type of information is to be released and/or disclosed:

	Initials		Dates From/To	
☐	_____	General medical information from	_____	_____
☐	_____	Laboratory tests (serum, urine)	_____	_____
☐	_____	Information regarding specific diagnosis or treatment	_____	_____
☐	_____	Other (nutrition, dental)	_____	_____

Requesting Practitioner Information (Note: below is where to send medical records, not where the patient has been seen):

Dr. Tulika Singh, MD
6565 N Avondale, Suite 1 at Breathing Room
Chicago, Il 60631
Phone (773) 250-1234 (EXT 0)

PRINTED Patient Name and Signature _____

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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 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.

Other physicians on your medical team 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 Dr. Singh.

I have read and understand the above:

Signature	Date
Witness	Date

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A. Notifier: Dr. Tulika Singh

B. Patient Name: _____ C. Identification Number: N/A

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **Dr. Singh** below, you may have to pay, i.e. pay for your appointment in the office, as your are accustomed to.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for **Dr. Singh** below.

D. Provider:	E. Reason Medicare May Not Pay:	F. Estimated Cost:
Dr. Singh	**Your appointment/s with Dr. Singh include services that are not covered by Medicare.**	N/A

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive care from **Dr. Singh** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want **Dr. Singh** listed above, but do not bill Medicare. Dr. Singh may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: Dr. Singh and The Healing Way Chicago will not bill Medicare for your visit. We accept cash payment and expect no additional payment from you or Medicare.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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Credit Card Authorization

Email (info@thehealingwaychicago.com) at the time of scheduling your first appointment and any time you want to update the card on file.

IMPORTANT: Security on the credit card processing system requires the information on this form MATCH EXACTLY what is on your credit card *AND* the billing statement you receive for this credit card.

If you use a middle initial on your card, please include it in the name section of this form. If you do NOT use a middle initial on your card, do NOT include it in the name section.

Please ensure the address on this form is the BILLING address for the credit card. In other words, the address on this form MUST be the address that prints on the BILLING STATEMENT.

I authorize Tulika Singh, MD to process payment of medical services, including a deposit for my initial appointment, balance on account, and/or a cancelation fee ($300 for new patient appointment, $200 for a double appointment, and $100 for follow up appointments) if I fail to provide a 3 business day cancelation notice, and/or for supplements and/or educational courses.

No charges shall be processed without *prior* written or verbal notice to the card owner.

ALL FIELDS MUST BE COMPLETED – PLEASE DO NOT LEAVE ANY BLANKS

Credit Card Type (Please circle one)

VISA MasterCard AMEX Diners Club

_____

Credit Card Number (Please PRINT CLEARLY on the line above)

_____ _____

Expiration Date: (Month/Year) **Security Code:** (3 or 4 digit number on back or front of card)

_____

PRINT Name on the line above, *AS IT APPEARS* on your credit card

_____

PRINT Street address and/or PO Box on the line above, *AS IT APPEARS* on your bill

_____

City **State** **Zip**

_____ _____

Phone number if questions **Email address for your receipt**

_____

Signature/Date - This form requires your signature.

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MEDICARE DENIAL

We are pleased that you have requested Dr. Tulika Singh to consult in your medical care. Medicare considers Dr. Singh's services to be educationally 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). For this reason, Medicare will not cover your clinical work up, evaluation or treatment through Dr. Singh. You will need to cover the cost of your appointments with Dr. Singh.

You may not bill your supplemental insurance because all services would need to be billed through Medicare first, and Dr. Singh does not participate or bill for Medicare covered services.

Dr. Singh 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.***

She 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 and clinic visits here do not fall under the usual and customary therapy covered by reimbursement by the Health Care Financing Administration (Medicare).

Your Signature: _____ Date:_____

PLEASE PRINT NAME HERE:_____

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