Optimal Health Center
74361 Highway 111, Suite 3
Palm Desert, CA 92260
(760) 568-2598

Treatment Authorization and Payment Policy:
(Please print)

I, _____ authorize the physicians, practitioners, and staff of Optimal Health Center to provide medical care and treatment for (check one)

_____ Myself

_____ My dependent or minor child, named _____
in accordance with the policies stated below:

Notice as to Nature of Services: I understand that care received at Optimal Health Center may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative medicine (CAM), holistic, or innovative services. This can include nutritional and herbal consultation, including alternative approaches to hormonal difficulties, and innovative laboratory testing and diagnosis. Many of these services may not be recognized as standard medical practice, and while long-practiced may still be considered investigational or experimental by the conventional medical community.

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 at Optimal Health Center.

Financial/Insurance Responsibility: The physicians and practitioners at Optimal Health Center do not participate in any insurance plans. I understand and agree that payment is required in full at each visit unless an alternative is agreed upon in advance; neither Optimal Health Center nor any of its physicians/practitioners take assignment. I am responsible for charges incurred for all treatment rendered, and agree that I am responsible for payments for services my insurance carrier may determine non-covered or excluded or to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory or other clinical services requested by my treating practitioner(s). I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Optimal Health Center to take action to secure payment of an outstanding balance owed.

Notice Regarding Insurance Reimbursement for Non-Participating Providers: I also understand that, if my plan provides reimbursement for services provided by nonparticipating providers, I may submit a claim myself to request reimbursement. I understand that it is my responsibility to know my plan benefits and that Optimal Health Center will not be responsible for determining or assisting me with collecting insurance benefits.

Credit/Debit Card On File: Optimal Health Center may require a valid credit or debit card be kept on file. I understand my card information will be encrypted and secured as part of my confidential chart in compliance with both HIPAA and credit card industry security standards. I agree to promptly update my credit/debit card information should it change or expire. I understand and agree that Optimal Health Center will apply charges to my credit/debit card on file for fees that occur as a result of my treatment – such as labwork, shipping, medical courier, processing, bank service, etc. – and that Optimal Health Center will notify me in such cases.

Accepted Methods of Payment: Optimal Health Center accepts credit cards, debit cards, cash, and checks as payment. This includes any health savings account (HSA) card containing a Visa or MasterCard logo. Optimal Health Center cannot currently accept the Care Credit program as payment.

Reservation, Reschedule, and Cancellation Policy: Optimal Health Center may require a valid credit card on file to reserve an appointment. I acknowledge that this card on file will not be charged until my appointment has concluded, and that I may use another accepted form of payment at that time. If I do not attend an appointment, or if I am unable to provide 24 hours notice of cancellation, I understand Optimal Health Center will charge my card on file for up to 50% of the office visit, including the cost of any materials used in preparation for the appointment.

Prescription Refill and Medical Form Policy: The practitioners and providers at Optimal Health Center receive a very high volume of requests for refill authorizations and medical form completion (school notes, jury summons exemptions, disability forms, etc). Due to this volume, one (1) week advance notice is required for all refill and form requests. I understand Optimal Health Center cannot be responsible for deadlines without sufficient advance notice. Further, I understand, at the practitioner's discretion, I may be required to attend an appointment with the practitioner for labwork and/or clinical review before refills or forms can be completed.

Product Return and Restocking Policy: Optimal Health Center will happily accept any unopened, unexpired supplement for a full refund. The container must be in good condition with safety seals intact. I acknowledge supplements custom formulated for me and/or containing my name on any labels may not be returned. Returns due to adverse clinical reactions will always be happily accepted.

Outstanding Balances, Returned Checks, and Chargebacks: Optimal Health Center may refuse to see patients with balances greater than $250.00 and/or over 30 days overdue, and who are not making regular payments on the balance. Outstanding balances greater than 90 days overdue may be referred to a collection agency. In the event of a returned check or credit card chargeback, Optimal Health Center will add a fee of $30.00 for each occurrence.

I have read, understand, and agree to the above terms and conditions

_____ _____

Signature of Patient (or legal guardian) Date