SXM SYMPTOM MEDICINE™
Pain Medicine, Palliative Care, Anesthesia

CHANTE S. BUNTIN, M.D.
824 Bay Avenue, Suite 70, Capitola, CA 95010
tel: 888.796.6331 fax: 888.796.6330

TERMS AND CONDITIONS OF SERVICE

Date

Patient Name ____
Address ____
____
____

Account MR______________________
DOB _____________________________
Age/ Sex _________________________

There are three pages for the SXM Terms and Conditions of Service. Please read the agreement in its entirety, initial each page and sign the agreement. "Clinic" is Chante S. Buntin, MD Inc, Symptom Medicine. "Undersigned" or "Patient" is _________________________________ and patient representative and relationship _____________________________ ___________________________. The undersigned, agrees to fully comply with all the Terms and Condition of Services, and Clinic's policies and rules of the Chante S. Buntin, MD, Inc/Symptom Medicine Clinic. Failure to comply with any such terms, rules and/or polices may result in the discharge from Clinic. If Undersigned is not Patient, "Patient Representative" and Patient agree to the financial terms of this agreement jointly and severally liable to pay the account of Clinic This agreement will be in effect for the duration Patient receives services at Clinic.

Primary Care Physician: The undersigned understands Clinic is a consulting medical service and has listed ________________ ____________________________ as the Primary Care Physician (PCP). The undersigned agree to maintain a PCP that is responsible for Patient's ongoing medical care at all times while a patient at Clinic.

Medical Consent: The undersigned and/or Patient Representative, hereby authorize and consent to Clinic to administer medical treatment, including, but not limited to medical examinations, treatments, diagnostic procedures, medication administration, laboratory procedures, therapeutic interventions/procedures, and emergency treatment, during the course of Patient's care as an inpatient, outpatient or home care patient as deemed advisable or necessary. The undersigned also consents to and authorizes demonstration and/or observation of Patient during the administration of medical treatment by physicians, student nurses and any proper student or technician whose presence deemed appropriate by the attending physician. .

Photographs: The undersigned agree and consents Clinic and its staff to take photographs for clinical purposes, surgical procedures, educational and/or patient identification. If the photographs are used in the public domain, the patient will not be specially identified by writing or depiction. .

Personal Property The undersigned understands and agrees Clinic does not assume responsibility for any personal property. The Clinic cannot hold any personal property, including but not limited to dentures, glasses, money, keys, wallet, jewelry, purse, documents, clothing and/or any other unmanned tangible property, in safekeeping and shall not be liable for any loss of or damage to any personal property.

Language Services: The Clinic is only fluent in English and does not have interpretation services for any language. If Patient does not speak or read English and wishes services from Clinic, Patient must provide her/his own interrupter who is fluid and versed in the written and spoken language of English.

Legal relationship with other Physicians and Health Care providers: All Physicians and health care providers are independent contractors or agents of other factions unrelated to Clinic, and are neither employed by, representatives, or agents of Symptom Medicine and/or Chante Buntin, MD Inc. The Patient understands that each physician and health care providers acts independently, directly and or indirectly, from Clinic for the purpose of providing professional services, and are liable and responsible for all such purposes. The undersigned recognizes that physicians and other health care providers furnishing services to Patient are all independent and separate from Symptom Medicine and/or Chante Buntin, MD Inc.

 Name____ Initials __________

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Release of Medical Information: The Clinic will obtain Patient's written authorization to release information, except those circumstances when Clinic is permitted or required by law to release information. The undersigned agrees that to Determine responsibility for payment and to obtain reimbursement, Clinic may disclose portions of Patient's record, Financial records, including but not limited to insurance companies, Social Security Administration, health care service Plans, worker's compensation carriers, corporations or persons who are or may be responsible for all or any portion of the patient's account. For Worker's Compensation of any kind, litigation of any kind, disability insurance, Social Security Administration, and managed care insurance companies, it may be required by law, bound by the undersigned's circumstances and/or insurance policy to communicate Patient care to the physicians, medical providers, agencies or insurance companies involved in the patient's case management and medical care. The undersigned agrees that Patient information may also be released to other health facilities, pharmacies or physicians to ensure continuity of medical care, namely, but not limited to prescriptions, medical records, psychological records, medications, radiographic studies, laboratory studies, physician notes and treatments. The Clinic is legally permitted to release certain basic Patient information to the public about the patient, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning or other condition) and the general nature and condition of the injury to any member of the public requesting such information, including news media personnel, unless patient or patient's legal representative makes a request to withhold such information. Special permission will be obtained to release information where Patient is being treated for drug or alcohol abuse.

Financial Agreement: Before any service can start, Clinic reserves the right to require proof of Patient's ability to pay Clinic account and may require full payment prior to any services. Unless other written arrangements are made with the Clinic, the undersigned agrees that in consideration of the services to be rendered by Clinic, Patient to accept full responsibility to pay the undersigned Clinic account in accordance with the regular rates and terms of Clinic. If the undersigned is not the patient, the undersigned and patient agree jointly and severally liable to pay the account of Clinic. The undersign understands that Clinic account is due and payable every seven (7) calendar days with the total balance paid in full on the 3oth of each month or prior to the next appointment, whichever comes first. Any payment shall be applied to the total bill owed. All undersigned accounts with outstanding delinquent payment and bills greater than 90 days will be reported to the Credit Bureau, unless prior agreements made and agreed upon. Should Patient fail to pay Clinic account in full as required by this agreement, the patient acknowledges that such a failure will cause Clinic to suffer financial damages that are difficult to ascertain. Accordingly, if Patient does not pay his/her account balance in full when due , the undersigned agrees to pay interest on all such delinquent amounts at the rate of 18% per annum or 1.7% per month, and a late payment fee of $30.00, plus all the actual legal and other costs associated with collecting said delinquent balances. Insufficient fund charged to Patient Clinic account on all checks is $30.00 per event. Missed appointment fee is $50.00. The Patient agrees that said charges are reasonable and a fair estimation of the damage the Clinic will suffer as a result of the patient's failure to pay in full the account of the Clinic when due.

Assignment of Insurance Benefits: The Clinic maintains a list of the health care service plans with which it contracts. A list of such plans is available upon request at Clinic. If Clinic has no contract, expressed or implied, it is not on the list. The undersigned has primary financial responsibility for all unpaid amounts and all services, even if Clinic agrees to accept payment directly from the responsible Payors, except otherwise provided under applicable law or regulation. The Clinic shall credit Patient's account with all amounts received on behalf of the patient from Patient's Payors. Before any services can start, pre-authorization from Patient's insurance carrier is required and pre-authorization is obtained by Patient. Undersigned understands if preauthorization is not obtained, services are denied services, or services precedes or exceeds the effective dates assigned by Patient's health care plan, Patient is financially responsible for all incurred fees. The undersigned must meet all financial responsibilities and pay all required fees before services can start. The undersigned agrees that he/she is obligated to pay and is responsible for the full charges and/or any unpaid amounts for of all services rendered to Patient which is not covered under the relevant health care service plan, this includes but not limited to uninsured medical services, fee for service, deductable, co-insurance, co-payment, and non-covered services. To the degree permitted under applicable insurance policy, health care service plan or third party payor agreement ("insurance"), the undersigned hereby irrevocably assigns and authorizes Chante S. Buntin, MD, Inc., and/or Symptom Medicines to direct all Payors insurance benefits, proceeds, or policy provisions payable to or on behalf of the patient for services rendered otherwise payable to the patient to make payments for medical services and/or professional fees directly to Chante S. Buntin, MD, Inc., and/or Symptom Medicine.

Medicare Participants: Medicare patient's lifetime beneficiary claim authorization: the undersigned certifies that the information given by Patient in applying for payment under title XVIII of the Social Security Act is correct. The undersigned authorizes payment of Medicare benefits be made on Patient's behalf directly to Dr. Chante S. Buntin, MD, Inc. and/or Symptom Medicine. In the Medicare assigned cases, the physician agrees to accept the charge determination of Medicare

 Name____ Initials __________

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carrier as the full charge, and the patient is responsible only for the deductable, co-insurance and non-covered services. The undersigned authorizes Chante S. Buntin, MD, Inc. and/or Symptom Medicine to release of all necessary information/records to the Social Security Administration for to secure the payments of these benefits.

Missed Appointments: All appointments require a 24 hour notice of cancellation. For any missed appointment where a 24 hour notice is not communicated to Clinic, a charge of $50.00 will be applied to Patient account.

Administrative: Terms and Conditions of Service (pg 2 of 3) Patient Name ______________________________
Payments Accepted: All unpaid Clinic accounts must be paid in full before any service is rendered. Payment for services, to name a few but not limited to uninsured medical services, fee for service, deductable, co-insurance, co-payment, and non-covered services may be secured with a valid credit card, cash or voided check for automated check withdrawal. Uninsured medical services, fee for service, deductable, co-insurance, co-payment, and non-covered services and so forth, will require payment via cash or credit card before any Patient services. Patient may be able to place a credit card on file and/or copy of a voided check on file at Clinic for revolving services. **:**

Agreement to Binding Arbitration: The undersigned understands and agrees to arbitrate any dispute and/or claim arising from any, direct or indirect, Clinic service, including but not limited to any service, treatment, procedure, medical malpractice, personal injury, privacy. The Undersigned agrees that any complaint or claim must be arbitrated (binding) and not by lawsuit or resort to court process as California law provides for judicial review of binding arbitration proceedings.

Privacy Rules and HIPPA: The undersigned was informed of Patient Rights and offered literature.

Patient Rights Title 22, California Code of Regulations: The undersigned was informed of Patient Rights and offered literature.

Patient Privacy and Self Determination Act: Undersigned acknowledge that I have been offered literature for the Privacy Practices under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), patient Rights and Responsibilities. I was also informed this information is available in the Clinic and an-line. I was also offered the following forms:
POLST DPOA Health Care Proxy DNI/DNR Advance Health Care Directives

Responsible Party (If other than Patient, indicate relationship): The undersigned patient certifies that he/she has read the foregoing, received a copy thereof, and all my questions were answered. The Patient, legal patient representative or duly authorized by the Patient (as the Patient's Representative) to execute the above and to accept its terms on behalf of Patient who shall be bound thereby.		
Patient Signature	Name:	Date and Time
Patient Representative Signature	Name: and Relationship	Date and Time
Witness Signature	Name:	Date and Time

Financial responsibility agreement by person other than Patient: I agree to accept joint and several financial responsibility with Patient for services rendered to Patient and accept the terms set forth above and received a copy.		
Patient Signature	Name:	Date and Time
Patient Representative Signature	Name and Relationship	Date and Time
Witness Signature	Name:	Date and Time

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