Steven Phillips MD PC

944 Danbury Road • Wilton, CT 06897 • Tel 203-544-0005 Fax 203-544-2228 • StevenPhillipsMD.com

Thank you for choosing us for your medical care. Please note that cases of vector-borne illness vary greatly between patients, as do responses to treatments. As such acceptance here as a patient here does not guarantee that we can cure your condition, but we'll sure try our best. Please fill out and sign each page of this form.

Timing & Fees Dr. Phillips	Initial Consult Time: 2 hours Initial Consult Fee: $2,000 • On average we spend an additional 1½ -2 hours working on your case before & after your initial visit	Follow-up Visits: 30 min Follow-up Fees: $650 • Frequency varies but is usually every 8 to 12 weeks
Timing & Fees Nurse Practioner	Initial Consult Time: 2 hours Initial Consult Fee: $1375 • Dr. Phillips is available to NP for questions, but you will only be seeing NP, not Dr. Phillips	Follow-up Visits: 30 min Follow-up Fees: $525 • Frequency varies but is usually every 8 to 12 weeks
Labs	We order detailed lab work but try to stay within your network. I understand that confirming insurance coverage of labs ordered for me by Dr. Phillips or his associates is my responsibility and that if I fail to do so, I will be financially responsible. For most tests, we are generally satisfied with chain labs like Quest, Bioreference, & Labcorp, as well as hospital labs, which take most insurance plans. Please specify which lab is covered best by your insurance and if you don't know, check your coverage in advance of your appointment. If you don't have medical insurance, let us know: Many of the major chain labs offer significant discounts in such cases. If the standard initial lab panel was not to be covered by insurance, it would cost approximately $3,000. We frequently order a limited amount of tests at specialty labs, which may or may not be covered by insurance. If these were not to be covered by insurance, they typically would cost less than $400. We regularly order basic lab tests to monitor blood counts and organ function during treatment. These monitoring blood tests are for safety purposes and are mandatory.	

I understand and agree to all policies and fees as described on every page of this form and give permission to have my credit card charged accordingly.

X_____ X_____ X_____

Patient or Guardian Printed Name Patient or Guardian Signature Date

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<table>
<tr><td>If You Need to Cancel or Re-schedule</td><td colspan="2">A lot of work goes into preparing for your appointments, so please:
Come to the appointment 5-10 minutes early.
Do not cancel or re-schedule at the last minute. This prevents us from seeing other patients who need an appointment, lengthens the waiting list, and raises administrative costs. For this reason, we charge fees for both new and follow up visits that are cancelled or re-scheduled without 5 business days advance notice for new patients, and 2 business days advance notice for established patients.</td></tr>
<tr><td>Refundable & Non-refundable Fees for Scheduling a New Appointment, Missing Appointments, Cancellations, & Re-scheduling</td><td><u>Initial Consults</u>
<u>A deposit by credit card of $500 is due to schedule your new patient appointment and will be applied toward your balance. If your appointment is cancelled or rescheduled with more than 5 business days advance notice, your deposit will be refunded in full. If your appointment is cancelled without at least 5 business days advance notice, the $500 deposit is Non-Refundable. If it is rescheduled without at least 5 business days advance notice, a $250 fee will be charged.</u>
If our office cancels your initial appointment for any reason, your entire paid fee will be refunded.
<u>Business days are Monday-Thursday</u></td><td><u>Follow-up Visits</u>
<u>We charge a $75 Non-Refundable fee for appointments cancelled or rescheduled within less than 2 business days of the scheduled appointment date.</u>
<u>Our business days are Monday through Thursday 9am-3 pm</u></td></tr>
</table>

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Insurance	**We do not participate in, or submit paperwork to, any insurance programs, and are considered out of network for private insurance.** • We provide you with a superbill for the office visit which you may submit to your private insurance, but coverage is not guaranteed. It's your responsibility to check your coverage with your insurer prior to your appointment so that you are informed as to the coverage, or lack of coverage, for your visits with us. • We have opted out of Medicare and only see Medicare patients under private contract, which means that Medicare will not cover your office visits here. Generally, Medicare will still cover lab work, radiology tests, and medications. This private contract requires Medicare patients to not seek reimbursement from Medicare for our office visit charges.
How to Prepare for Your Appointment	• Please send digitally or by fax blood test results, radiology reports, neurologic testing, cardiac testing, and pertinent doctors' notes for the past 1 year only, as well as all tests you've ever had for Lyme and any other infections. **Please send separate digital files or separate faxes for each of those categories: This means a separate fax for blood test results, radiology reports, neurologic testing, cardiac testing, and pertinent doctors' notes. We no longer accept paper medical records.** • Please know all your medications and dosages. • It's usually helpful to bring a loved one or good friend with you during your initial appointment. There's a lot to go over and we'd like to make sure that we're communicating effectively.

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X_____ X_____ X_____

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Cancellation/Re-Scheduling Fees—Calculating Business Days Advance Notice

We include the day you called and the day of your appointment in your advance notice calculation. Non-business days, which are Fridays, Saturdays, and Sundays, are not included in advance notice calculations.

Credit Card Authorization

I authorize Steven Phillips, MD PC to charge my credit card for the fee schedule outlined on pages 1-4 of this form. This authorization will remain in effect until cancellation. To cancel, I must give a 60 days notice in writing and the account must be in good standing. If I dispute the credit card charges with my credit card company, I allow Steven Phillips, MD PC to disclose my HIPAA protected health record to the credit card company in order for the credit card company to investigate that dispute.

□ Visa □ Mastercard

Credit Card Number: _____ Expiration Date: _____

3 Digit Security Code: _____ Billing Zip Code: _____

I understand and agree to all policies and fees as described on every page of this form and give permission to have my credit card charged accordingly.

X_____ X_____ X_____

Patient or Guardian Printed Name Patient or Guardian Signature Date

Cell #:_____ Home #:_____ Email: _____

Which health care provider would you like to see? _____