

Michael F. Cantwell MD, MPH
(CA License #: G060393)
1501 Clement Street | San Francisco, Ca 94118
Phone: (415) 831-4412 / Fax: (415) 831-4416
www.mcmand.us

PARKING INFORMATION

There is ample parking near the office. Below is a listing of options:

Free Street Parking:

There is free street parking with no time limit on most nearby streets. Check signage.

Parking garages and lots (listed nearest to farthest):

- Geary Mall Garage (midblock between Geary and Clement)
Geary Blvd, San Francisco, CA 94118
M-F 5:30am – 11pm / Sat and Sun 9am – 11pm
\$1 per Min / \$3 – per hr / \$18 max per day / \$21 overnight
- 18th Ave./Geary Lot
421 18th Avenue, San Francisco, CA 94121
Mon-Sun 9:00 am–12:00 am
\$2 per hour

Metered Street Parking:

There is rapid turnover of metered street parking on Geary Street, one block south of the office. Meters cost \$2.50 per hour and have a 2 hour maximum. Meters accept coins, SFMTA parking meter cards, and mobile pay-by-phone options (may have additional charges) and most major credit cards. Free parking after 6 pm.

Drop-off/Pick-up:

There is a white parking zone directly in front of our building for passenger drop-off and pick-up only.

DRIVING DIRECTIONS

From Marin:

Continue on Hwy 101 South after crossing the Golden Gate Bridge. Using the 2 right lanes to take exit CA-1 toward Golden Gate Park/19th Ave. Turn right on Clement Street. The office is 3 blocks down on the left, on the corner of Clement and 16th Ave.

From the East Bay:

Using Bay Bridge:

After Crossing the Bay Bridge use the right 2 lanes to merge Hwy 101 North toward Golden Gate Bridge. Continue onto Octavia Blvd. Turn left onto Fell St. Slight right to stay on Fell St. Turn right onto Stanyan St. Turn left onto Fulton St. Turn right onto 16th Ave. **The office is on the left, on the corner of Clement and 16th Ave.**

Continued on next page....



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Using Richmond / Golden Gate Bridge (2 tolls):

After Crossing the Richmond Bridge exit onto Sir Francis Drake Boulevard toward Hwy 101 S. Using the 2 left lanes merge onto Hwy 101 S toward San Francisco. After crossing the Golden Gate Bridge. Using the 2 right lanes to take exit CA-1 toward Golden Gate Park/19th Ave. Turn right on Clement Street. The office is 3 blocks down on the left, on the corner of Clement and 16th Ave.

From the South Bay (via Hwy 101):

Take I-280 N Using the 3 left lanes to take exit for CA-1 N toward 19th Avenue/Golden Gate Bridge. Continue north, in Golden Gate park take a slight left onto Crossover Dr. Turn right onto Fulton St. Turn left onto 16th Ave. The office on the right, on the corner of Clement and 16th Ave.

MUNI/BUS DIRECTIONS

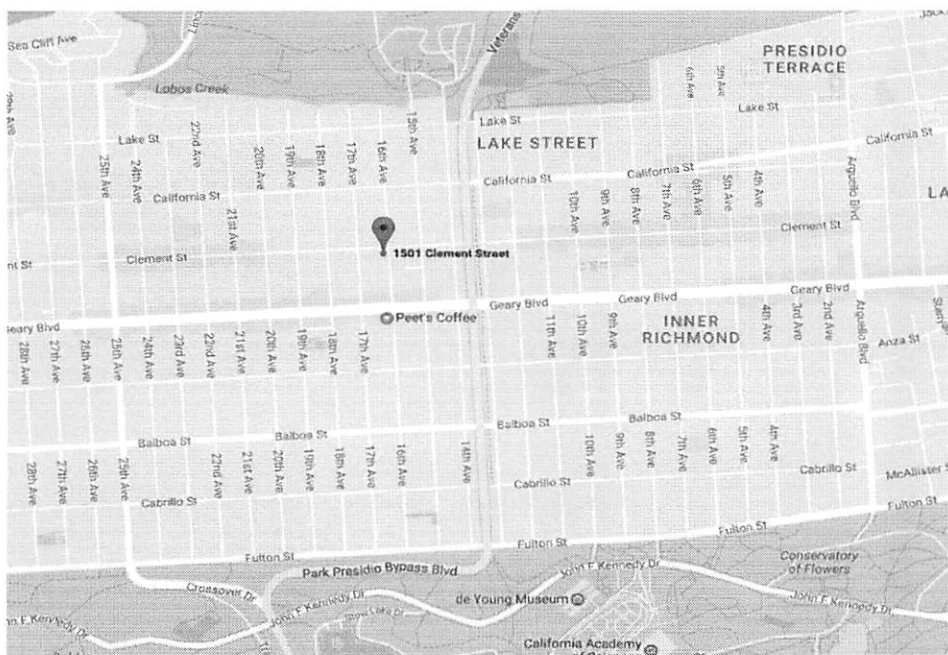
MUNI Line 38 & 38R (via Geary Blvd) – Westbound stops at 19th/ Park Persido Blvd and Geary Blvd.

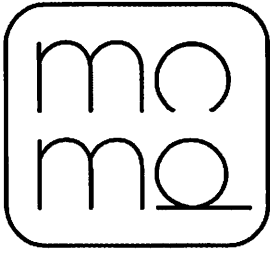
MUNI Line 2 (via Sutter St./ Clement St.) - Westbound stops at 14th and Clement St.

MUNI Line 1 (via California St) - Westbound stops at California and 16th Ave.

BART DIRECTIONS

Take BART to the Montgomery Street exit. Walk north east, 1 ½ blocks to **Market Street & Sansome Street bus stop** take MUNI Line 38 or 38R westbound. Exit at 19th/ Park Persido Blvd and Geary Blvd.





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Patient Information

1. NAME OF PATIENT: _____

a. NAME OF SPOUSE/SIGNIFICANT OTHER: _____

b. IF MINOR/CHILD:

1. NAME OF MOTHER: _____

2. NAME OF FATHER: _____

3. NAMES/AGES OF SIBLINGS: _____

c. NAMES OF OTHER SIGNIFICANT FAMILY MEMBERS: _____

2. DATE OF BIRTH: ____/____/____

3. MAILING ADDRESS:

a. STREET: _____

b. CITY/STATE/ZIP: _____

4. TELEPHONE NUMBERS (IN ORDER OF PREFERENCE TO BE CALLED):

a. () - [___ Cell ___ Home ___ Work ___ Other: _____]

b. () - [___ Cell ___ Home ___ Work ___ Other: _____]

c. () - [___ Cell ___ Home ___ Work ___ Other: _____]

5. EMAIL: _____ @ _____

6. ALLERGIES:

a. TO MEDICATIONS: _____

b. OTHER: _____

7. CURRENT MEDICATIONS (if more room is needed please attach additional page):

i. _____

iv. _____

ii. _____

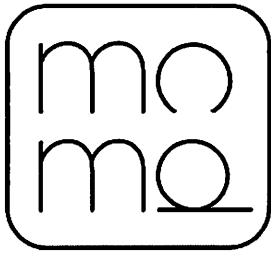
v. _____

iii. _____

vi. _____

vii. _____

viii. _____



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Informed Consent – Practice/Holistic Philosophy

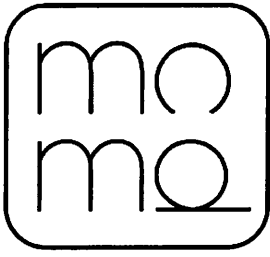
1. Practice Philosophy: As a holistic physician, Dr. Cantwell views health and disease as being influenced by any and all aspects of an individual-the physical, mental/emotional, and/or spiritual. There are many factors involved in the origins of disease, including genetic vulnerability, nutrition, allergic or immunological reactions, physical or environmental toxins, psycho-emotional stress, trauma, or conditioned psychological patterns, and spiritual stress and disharmony. Whenever possible, Dr. Cantwell seeks to treat disease at its most fundamental, root level, whether it lies in one' s body, mind, or spirit.

Although Dr. Cantwell takes an evidence-based approach to treatment, using therapies that are supported by animal models, extensive observation and anecdotal data, case series data, and wherever possible, controlled clinical trials, many of the therapies recommended are considered alternative, investigational, and/or experimental by the allopathic/conventional medicine community. In general, Dr. Cantwell seeks to employ treatments that, based on the existing literature, are significantly more likely to have positive, beneficial effects on health than to have adverse effects. However, as with medications and many other conventional medicine treatments, there is always risk, albeit small, of an adverse effect.

2. Holistic Medicine in California: In California, in compliance with Business & Professions Code 2234.1 (a) (1), such alternative and/or complementary services may only be provided after:

- 1) informed consent,
- 2) a good-faith prior examination of the patient, and
- 3) medical indication exists for the treatment or advice, or it is provided for general health or well-being.

Business & Professions Code 2234.1 (a) (3) and (4) states that the alternative and/or complementary treatments not cause a delay in, or discourage traditional diagnosis of, a condition of the patient, nor cause death or serious bodily injury to the patient. By signing this form, I acknowledge I have been apprised of Business & Professions Code 2234.1.



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Informed Consent – Practice/Holistic Philosophy (Page 2)

3. Informed Consent: I recognize that I will be able to ask questions and clarify any concerns with Dr. Cantwell prior to beginning any recommended treatment. I recognize that I am a partner in treatment decisions and will be informed of the risks and benefits of recommended treatments by Dr. Cantwell. After being duly informed by Dr. Cantwell of my condition and the risks and benefits of conventional allopathic and alternative and/or complementary treatments, I will then decide whether to proceed with alternative and/or complementary treatments. It is also my choice whether or not to combine any alternative and/or complementary treatments I choose to undergo with conventional/allopathic treatment. My physician will respect my ability to make my own decisions and will not discourage me from seeking conventional/allopathic treatment.

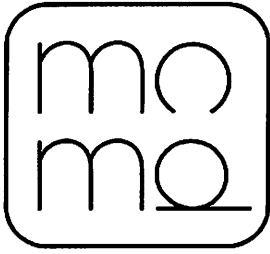
4. Confidentiality Policy: We will only share your health information with others after we have received your written consent to do so or in the event that you have submitted a claim to your health insurance company and that company requests that we share health information relevant to that claim. You can request a copy of your medical records from the clinic at any time for your personal use.

I understand the approach to health and wellness offered by Dr. Cantwell. I acknowledge I have been apprised of California State Business & Professions Code 2234.1. I understand that some of the treatments recommended may be considered alternative or experimental by those in conventional/allopathic medicine. With that knowledge, I choose to participate in this holistic/integrative approach to medicine and the treatments recommended.

I have been given my own copy of this signed form.

Patient Signature: _____ Date: _____

Printed Name: _____



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Cancellation and Billing Policies (page 1)

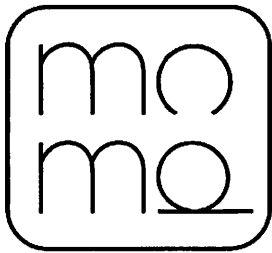
1. Cancellation Policy: You must call Dr. Cantwell's administrative coordinator at (415) 831-4412 to make any cancellations. Cancellations made four or less days before a scheduled appointment are considered "late cancellations and will be charged at 50% of the fee of the scheduled visit. We require that all patients have a current credit card on file to use for billing "late cancellation" fees.

2. Billing Policy:

a. Current Rates: The base billing rate for Dr. Cantwell's services, as of 8/1/15, is \$365/hour (New Patient appointment: 90 minutes = \$550 (\$365/hour x 1.5 hours), Established Patient appointments: 60 minutes=\$365, 45 minutes= \$275, 30 minutes=\$185, 15 minutes=\$90). In-office and telephone visits are billed at the same rate. Dr. Cantwell reserves the right to increase these rates in the future. Administrative time, such as letters, correspondence with insurance companies or other practitioners, frequent or long email responses or telephone calls, may be billed at the base hourly rate.

b. Payment: Payment is expected at time of service. We accept cash, check, Visa, and MasterCard. We require that all patients have a current credit card on file. Patients who do not remain current with payment of their billed fees may be refused service and payment will be attempted through the credit card on file and/or through bill collection services.

c. Insurance: WE DO NOT BILL OR CONTRACT WITH ANY INSURANCE COMPANIES. At the end of your visit, you will be given a superbill with ICD10 diagnosis codes and CPT procedure codes that you can submit to your health insurance company to attempt to obtain reimbursement for services rendered at out-of-plan rates. (EXCEPTION: MEDICARE PATIENTS will be given a receipt but not a superbill to prevent submission of any claims to Medicare, Medi-gap. or other Medicare supplemental insurance plans-see separate consent form for Medicare patients). Depending on the physician or staff time involved, we reserve the right to bill for reports, letters or other documentation to support claims for reimbursement sent to your health insurance company.



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Cancellation and Billing Policies (Page 2)

I have read, understand, and will abide by the above policies regarding cancellations and billing. The below credit card is current and valid and, I understand, will be used for "late cancellation" fees or unpaid fee balances as described above, unless other forms of payment have been arranged with Dr. Cantwell.

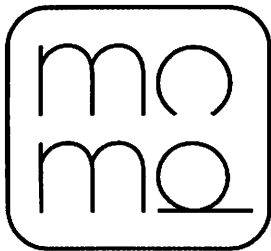
I have been given my own copy of this signed form.

Credit card: Visa Mastercard Card # _____

Exp: ___/___ Card Security code (3 digits from back) _____

Patient Signature: _____ Date: _____

Printed Name: _____



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Policies and Procedures

Not a Primary Care Practice: The medical practice of Michael F. Cantwell MD, MPH is not a primary care office. I do not provide primary care services or urgent care service. I require my patients to have a primary care physician (PCP) and provide my office with PCP's contact information.

Hospitalization/Urgent or Acute Care: I have only consulting medical staff privileges at California Pacific Medical Center and am unable to be the admitting or attending physician for any hospitalized patients. I do not provide urgent, acute, or immediate care at my office.

No On-call Physician: I do not have practitioners on call for emergencies. If any of my patients are experiencing an emergency medical situation, they are advised to contact 911.

Email Communication: I often maintain email contact with patients for non-urgent communications. If excessive emails are sent in-between appointments or require more than 5 minutes to reply a fee billed at my hourly rate may be charged to the credit card on file. Emails sent by myself or my staff is HIPPA compliant through G Suite.

Contact information for your Primary Care Provider (PCP):

Name: _____ Phone #: _____ Fax: _____

_____ I do not have a Primary Care Physician and I am aware that Michael F. Cantwell MD, MPH will not be responsible for my primary care.

Would you like us to contact your primary care provider for a copy of your records?

Yes___ No___ (If "Yes" please fill out a Records Release form.)

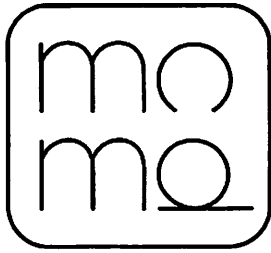
Would you like us to contact your primary care provider to inform him/her of your care and treatments with Michael F.

Cantwell MD, MPH? Yes___ No ___

If yes, I give my consent for Michael F. Cantwell MD, MPH and staff to provide information about my medical situation and treatments to my Primary Care provider.

Patient Signature: _____ Date: _____

Printed Name: _____



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Medicare Patient Policy (page 1)

Dr. Cantwell's practice does not bill or contract with any health insurance plans, neither private nor Medicare, Medi-gap or other Medicare supplemental insurance plans. If you are covered by Medicare or a Medi-gap or other Medicare supplemental insurance plan, after your visit you will receive a receipt for payment, not a superbill with CPT procedure and ICD10 diagnostic codes. This is to avoid any potential for submission of superbills to Medicare or Medi-gap or other Medicare supplemental insurance plans for services rendered by Dr. Cantwell.

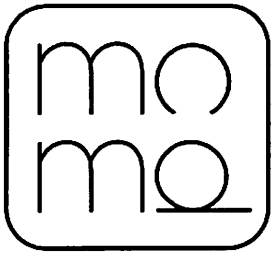
Explanation:

In the case of a patient covered by private PPO insurance, ie. NOT associated with Medicare or a Medi-gap or Medicare supplemental insurance, the patient pays Dr. Cantwell's fees at the time of the visit and then submits the superbill to their insurance. The insurance reimbursement is paid directly to the patient and offsets their initial payment to Dr. Cantwell. This does not limit Dr. Cantwell's fees or visit times.

In the case of a patient covered by Medicare or a Medi-gap or Medicare supplemental insurance, Medicare limits the AMOUNT a physician can charge for a specific service and also the maximum TIME allowed per visit (for example maximum time allowed for a visit would be 45 minutes). If a superbill is submitted to Medicare for services rendered by Dr. Cantwell, this would limit both his fee and the time he can take with patients. This is true regardless of whether the patient has straight Medicare insurance or a Medi-gap or Medicare supplemental insurance (Since all Medi-gap and Medicare supplemental insurance policies first submit their bills to Medicare, this still subjects Dr. Cantwell to the same limits on fees and visit times imposed by Medicare).

In addition, Medicare has increasingly been levying significant fees (up to \$20,000) to physicians, such as Dr. Cantwell, who treat Medicare patients but who do not submit superbills directly to Medicare or subject their fees or visit durations to strict Medicare limits.

At present, Dr. Cantwell is seeing patients covered by Medicare and Medi-gap or Medicare supplemental insurance policies. This is subject to change in the future if patients covered by Medicare submit superbills to Medicare, limiting Dr. Cantwell's fees and visit times and exposing him to potential fees or other administrative action by Medicare.



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Medicare Patient Policy (Page 2)

I have read the above and understand that, as a patient covered by Medicare or a Medi-gap or other Medicare supplemental insurance plan, I will receive a RECEIPT for payment, NOT A SUPERBILL (with CPT procedure and ICD10 diagnostic codes) for services rendered by Dr. Cantwell. I agree not to submit this receipt to or in any other way attempt to seek reimbursement from Medicare or any Medi-gap or Medicare supplemental insurance for services rendered by Dr. Cantwell.

If, in any manner, I or my agents submit a claim or superbill to Medicare or a Medi-gap or other Medicare supplemental insurance plan for services rendered by Dr. Cantwell. I agree to assume full responsibility for complete and immediate reimbursement to Dr. Cantwell for: 1) Dr. Cantwell' s original charged fees, 2) any fees or penalties imposed on him by Medicare related to submission of that claim or superbill, and 3) any administrative time needed by Dr. Cantwell to deal with submission of that claim or superbill (billed at Dr. Cantwell' s current hourly rate).

I also understand that submission of a claim or superbill to Medicare or a Medi-gap or other Medicare supplemental insurance plan constitutes sufficient grounds for dismissal from Dr. Cantwell' s practice.

I have been given my own copy of this signed form.

Patient Signature: _____ Date: _____

Printed Name: _____

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.

By: _____
Physician's or Duly (Date)
Authorized Representative Signature

By: _____
Patient's Signature (Date)

Print Patient's Name

By: _____
Print or Stamp Name of Physician,
Medical Group or Association Name

By: _____
Patient's Representative's Signature (if applicable)(Date)

By: _____
Signature of Translator (if applicable) (Date)

Print Name and Relationship to Patient

Print Name of Translator