**Dr. Vyacheslav Alec Pekler NMD**
**7025 Aldea Ave., Lake Balboa, CA 91406**
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## AUTHORIZATION & ACKNOWLEDGEMENTS
☐ INITIAL ☐ ANNUAL UPDATE

**TREATMENT AUTHORIZATION**: I (print name) _____ authorize medical treatment of myself or my minor child by **Dr. Vyacheslav Alec Pekler and his staff**.

**NOTICE AS TO NATURE OF SERVICES**: I understand that the care I receive at **Dr. Vyacheslav Alec Pekler** may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine, or innovative services. Many of these services may not be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my physician may request laboratory testing which may include venipuncture, analysis of stool, urine, saliva and breath.

**NOTICE THAT SERVICES ARE NOT PRIMARY CARE**: *I understand that no physician or any other practitioner I see at* **Dr. Vyacheslav Alec Pekler** *is acting as my primary care doctor unless otherwise agreed to by a physician in writing*. As such, emergency services are not offered. I understand that even though my physician(s) and DrHakunaMatata.com practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are 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 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 to inform **Dr. Vyacheslav Alec Pekler** who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at **Dr. Vyacheslav Alec Pekler** in order to properly and safely coordinate my care.

**My primary care physician is:**

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

I am also being treated for _____ by:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

**FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL Dr. Vyacheslav Alec Pekler SERVICES**: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at each visit; **Dr. Vyacheslav Alec Pekler** does not accept assignment. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses because differences between integrative and conventional medicine can lead to differences in views about medical necessity. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees

for laboratory and/or other clinical and diagnostic testing and/or services requested by my treatment practitioner(s). **Dr. Vyacheslav Alec Pekler** will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for **Dr. Vyacheslav Alec Pekler** to take action to secure payment of an outstanding balance owed.

**CANCELLATION AND/OR NO-SHOW POLICY:** The clinic urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least 48 hours notice (Mon – Thurs). Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a **charge not less than fifty percent of the full visit fee for each occurrence**.

**NOTICE TO MEDICARE PATIENTS**: The doctors at **Dr. Vyacheslav Alec Pekler** have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at **Dr. Vyacheslav Alec Pekler.** I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said services(s).

**CLAIM MANAGEMENT & DOCUMENTATION REQUESTS**: My treating practitioner(s) may respond to insurance and or documentation 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 will be charged for responding to requests for information based on a rate of **$550.00 per hour**. Insurance claim forms and information will be provided to patients at the time of visit or sent to you upon the availability of the appropriate documentation. **Dr. Vyacheslav Alec Pekler**, and/or it's representatives do not make court appearances unless subpoenaed.

**FURTHER NOTICES AS TO POLICIES REGARDING INSURANCE**: **Dr. Vyacheslav Alec Pekler** will provide claim forms for submission to insurance; submission shall be the patient's responsibility. Claim submissions may or may not be for covered services and may or may not include procedural codes or other data sufficient to support my insurer's determination as to what services it will reimburse. **Dr. Vyacheslav Alec Pekler** may provide records requested by my insurance company. If possible, **Dr. Vyacheslav Alec Pekler** will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions,

**NO GUARANTEES**: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at **Dr. Vyacheslav Alec Pekler.**

**REVOCATION OF AUTHORIZATIONS**: These authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

**PATIENT ACKNOWLEDGMENT**: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.
In additional to the consultation, additional medical laboratory tests may be ordered based on your condition and you will be presented with detailed information on why the **specific tests** are recommended. **The cost for your initial laboratory tests will be discussed at that time and is different for every patient.** The results of your lab tests may take approximately 3 to 6 weeks depending on the tests ordered. An appointment to review your lab results takes approximately 45 - 60 min, or longer, depending on the complication of your case. You will be presented with a written report detailing the results of your tests, the possible causes of your health problems, and the recommended treatment protocol. Your cooperation in taking "personal responsibility" for your health care will be vital for treatment success. **It is suggested that you have your spouse or a supportive family member attend this appointment to help you on your health journey.**

Your treatment may consist of dietary and lifestyle changes as well as prescribed Natural Pharmaceuticals or Conventional Medical Interventions when deemed necessary.

**Additional Policies:**

It is strongly recommended that you have access to a computer and an Internet connection. A medical progress questionnaire will be posted to your electronic health record portal one week before your next scheduled appointment. Completion of the questionnaire is required every 6-12 weeks to monitor your progress. If you do not have access to the Internet, a copy of the progress questionnaire will be mailed or faxed to you.

Correspondence by e-mail is free for basic questions and communication. Please keep emails short and to the point. Please expect his responses may be delayed by several days or more. Should you need an immediate response, please call the doctors; personal line at **(818) 635-1970**. Emails that require a lengthy or detailed answer will be referred to an appointment with Dr. Pekler instead.

Follow-up consultations are scheduled approximately every 1 month, 3 months, 6 months and 12 months so we can discuss your progress and any concerns with Dr. Pekler. At these times, Dr. Pekler will determine what direction to take to help you progress. Consultations can be conducted either by phone, Skype or in person at the office.

Abnormal laboratory tests will need to be re-evaluated. Laboratory fees can vary depending on what needs to be re-tested. The success of your treatment will not only be measured by the reduction or elimination of your physical symptoms, but also on abnormal laboratory tests returning to a normal status.

**Payment is made at the time services are rendered and tests are ordered. Payments can be made via cash, check and/or credit card. We accept Visa, Master Card, Discover and American Express. A valid credit card must remain on file at all times.**

**I, have read and fully understand the Patient Acceptance Policy _____ (Initials)**

**Notice of Privacy Practices**

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as, how you can get access to this information. Please read this information carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff. Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the information to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Office for Civil Rights
U.S. Department of Health and Human Services

50 United Nations Plaza - Room 322
San Francisco, CA 94102
415-437-8310 (VOICE); 415-437-8311 (TDD); 415-437-8329 (FAX)

**Contact Person**
Dr. Vyacheslav Alec Pekler
7025 Aldea Ave
Lake Balboa, CA 91406

By signing and dating this form, I acknowledge that I have received a copy of **Dr. Vyacheslav Alec Pekler** Authorizations and Acknowledgements.

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| Patient's Signature or the Responsible Party:<br><br>Name: | Date: |
| Witness's Signature | Date: |