Clinical Paradigms, LLC

www.clinicalparadigms.com

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Patient Name: _____

Patient date of birth: _____

Month Day Year

Address: _____

Contact Number: _____ _____ _____

Which is preferred? ☐ *Home* ☐ *Mobile* ☐ *ext./ other* _____

E-mail Address: _____

Name, telephone & fax of **primary** physician:_____

Name, telephone & fax of **referring** physician:_____

Name and Telephone number of patient's pharmacy: _____

I authorize Clinical Paradigms the right to access my Medication List from pharmacy listed above

☐ Yes ☐ No Signature: _____

Telehealth Consultation Information

- The initial intake visits are 60 minute video consultations each and cost $325 combined. They will be scheduled first in order to get a broad overview of your health journey.

- You will be seen by any of our clinic's providers of your choosing and in accordance with your medical needs thereafter.

- Please check the package option on the price document you would like to pursue.

- ☐ Option 1 ☐ Option 2

Insurance typically DOES NOT cover fees for consultations with our health care providers

Upon request, we can provide an itemized invoice which the patient can submit to their insurance.
The office will not submit any invoices or bills on behalf of the patient to any insurance service and cannot guarantee any reimbursement will come as a result of invoice submission.
Please complete this form, email or fax it back at least 1 week prior to your appointment.

By signing and returning this form you agree to these terms.

Patient/Guardian Signature:_____

Credit Card (Mastercard or Visa)

Name on Card _____

Number_____Exp_____ CVV_____

Welcome! The following is the policy for an appointment to undergo an evaluation for Mast Cell Activation Disorder/Syndrome and Ehlers-Danlos Syndrome at Clinical Paradigms, LLC.

1. All patients must have a written referral letter from their local physician. All referrals and medical records as well as the filled out intake questionnaires should be uploaded through the Patient Fusion patient portal which becomes available *after* registration is complete.

We will not process records sent via email due to HIPAA Privacy Rules.

If already obtained, the records should include some of the following:

• Recent office visit notes • Blood test results • Biopsy reports (from endoscopies or bone marrow aspirations) • Hospital and emergency room visits	• Serum tryptase level, serum histamine level • A complete blood count with differential • 24-hour urine tests for N-methylhistamine, prostaglandin F2 alpha, and/or prostaglandin D2

2. Once your documentation is received, a representative from Clinical Paradigms will be in contact with you regarding when an appointment can be scheduled.

***Please note that no medical advice will be given nor will there be direct communication with patients who are not established with this practice. ***

3. It is the patient's responsibility to verify appropriate insurance coverage and to obtain referrals, if necessary. The staff members of Clinical Paradigms are not able to call insurance companies to verify insurance coverage, for the office visit or any laboratory testing. The office also does not have the resources to arrange referrals.

4. **No emergency appointments can be scheduled.**

5. The patient must have a local health care provider - doctor, physician assistant, nurse practitioner, who will follow them, when they return home, to provide ongoing management and care. **X_____ (initials)**

6. The initial consults with Dr. Brock, Dr. Maitland , and Dr. Pizano will be made following the environmental and nutrition intakes. Follow up appointments will be scheduled to discuss any further test results, treatment recommendations, and coordinate care with the health care provider(s) who will be responsible for ongoing treatment and care. A minimum of three to four appointments are suggested for diagnosis and treatment recommendations.

7. Routine medications (including antihistamines) **should not be stopped** prior to the appointment.

8. If the visit exceeds 90 minutes, any additional time will be billed accordingly, and will be the patient's responsibility at the end of the visit. **X_____ (initials)**

Patient/Guardian's Name: Patient/Guardian's Signature: Date:

X _____ X _____ _____