

**Thank you for contacting Dr. Jeffrey H. Chester's office.**

**Please follow these steps if you would like to become a patient in Dr. Chester's medical practice.**

Step 1: Please call our office to find out if we are currently participating with your medical insurance.

Step 2: Keep this page, along with the "Privacy Policies Notice" for your records.

Step 3: Complete pages 1 – 8 and return them to our office by fax or US Postal mail.

Step 4: Our office will call you once Dr. Chester has finished reading your paperwork and any prior medical records he may need to review.

**Our contact information:**

Dr. Jeffrey H. Chester, DO

Puuone Plaza Building

1063 Lower Main St, Suite C212

Wailuku, HI 96793-6006

808-249-8887 (phone)

808-249-8889 (fax)

[www.ponohealthcare.com](http://www.ponohealthcare.com)

[drchester@ponohealthcare.com](mailto:drchester@ponohealthcare.com)

## **PRIVACY POLICIES NOTICE – patient copy**

It is the policy of my practice and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that my practice and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to my practice and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, my practice and staff will--

- ☞ Adhere to the standards set forth in the Notice of Privacy Practices.
- ☞ Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. My practice and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- ☞ Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- ☞ Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. My practice and staff will
  - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- ☞ Recognize that patients have a right to privacy. My practice and staff respect the patient's individual dignity at all times. My practice and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- ☞ Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, My practice and staff will:
  - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - Not disclose PHI data unless the patient (or their authorized representative) has properly authorized the release or law otherwise authorizes the release. Recognize that, although my practice "owns" the medical record, the patient has a right to inspect and obtain a copy of their PHI. In addition, patients have a right to request an amendment to their medical record if he/she believe their information is inaccurate or incomplete. My practice and staff will--
  - Permit patients access to their medical records when their written requests are approved by my practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
  - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- ☞ My practice and staff will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- ☞ My practice and staff will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- ☞ My practice and staff must adhere to this policy. My practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- ☞ My practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

**PATIENT INFORMATION FORM**

**INSTRUCTIONS: PRINT WITH BLACK OR BLUE INK  
ALL INFORMATION PROVIDED IS CONFIDENTIAL**

LAST NAME: \_\_\_\_\_

FIRST NAME AND MIDDLE INITIAL: \_\_\_\_\_

PHYSICAL ADDRESS (required): \_\_\_\_\_  
\_\_\_\_\_

MAILING ADDRESS (if different from above): \_\_\_\_\_  
\_\_\_\_\_

GENDER:  Male  Female  Trans\*  \_\_\_\_\_

SOCIAL SECURITY NUMBER (last four digits): XXX-XX-\_\_\_\_\_

DATE OF BIRTH (month/date/year): \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELLULAR PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

WHICH PHONE NUMBER(S) CAN OUR OFFICE LEAVE CONFIDENTIAL MESSAGES FOR YOU? (check all which apply)  
 Home  Cellular  Work

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

EMERGENCY CONTACT PHONE NUMBER: \_\_\_\_\_

EMERGENCY CONTACT RELATIONSHIP TO PATIENT: \_\_\_\_\_

IF PATIENT IS A MINOR (UNDER 18 YEARS OF AGE), PLEASE PROVIDE PARENT/GUARDIAN INFORMATION:


NAME OF PARENT OR GUARDIAN: \_\_\_\_\_

PARENT/GUARDIAN PHONE NUMBER: \_\_\_\_\_

ADDRESS (IF DIFFERENT FROM PATIENT): \_\_\_\_\_  
\_\_\_\_\_

“PRIVACY POLICIES NOTICE” Acknowledgment:

I have read, understand, and received a copy of Jeffrey H. Chester, DO’s “Privacy Policies Notice.”

 \_\_\_\_\_  
Signature of Patient or Guardian Today’s Date

**FINANCIAL / INSURANCE INFORMATION FORM AND POLICIES FORM**

PRIMARY INSURANCE \_\_\_\_\_ MEMBER # \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ MEMBER # \_\_\_\_\_

TERTIARY INSURANCE \_\_\_\_\_ MEMBER # \_\_\_\_\_

I hereby authorize my insurance carriers to pay and hereby assign directly to Dr. Jeffrey H. Chester all benefits, if any, otherwise payable to me for services. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for myself and/or dependents, and that I will be bound by my signature as though the undersigned had personally signed the particular claim.

**Please initial your understanding of each statement:**

\_\_\_\_\_ I understand I am financially responsible for all charges incurred, whether or not paid by my medical insurance. I also acknowledge that any insurance benefits when received by and paid to Dr. Jeffrey H. Chester will be credited to my account, in accordance with the above said assignment. If I have not met my insurance's deductible and/or if I have a copayment associated with my office visits, I understand I am financially responsible. Accounts with outstanding balances may have interest applied at the rate of 1.5% every 30 days until the balance is repaid. Account balances more than 90 days old, may be forwarded to a collections agency, and an additional \$50 (fifty dollar) administrative fee added to the account.


\_\_\_\_\_ I understand that any payments and/or copays/copayments related to my medical services are due and collected on the date of service. Any copay not paid on the date of service will incur a \$10 administrative fee. Checks returned unpaid by the bank for insufficient funds will incur a minimum \$45 service fee.

\_\_\_\_\_ Dr. Chester's office does not overbook appointments. Reminder calls for appointments are a courtesy only. To avoid a fee from a missed appointment, canceling or rescheduling your appointment with less than 24 hours notice, you must contact our office more than 24 hours from your scheduled appointment's date/time. Our voicemail is available 24/7, and will timestamp your call. The penalty for a broken appointment is \$300 for emg/nerve testing appointments, and \$100 for all other appointments. Please note: if you missed your appointment because you were admitted to the hospital, please provide a copy of your hospital discharge summary to have your fee waived.

\_\_\_\_\_ Dr. Chester's office may charge an administrative fee to process the following: prior authorizations for medications; forms or documents which require Dr. Chester's review and signature; medication prescriptions which need to be re-written because the original was lost, stolen, misplaced, expired, or partially-filled.

\_\_\_\_\_ I understand that Dr. Chester may forward medical notes related to my medical care to other healthcare providers, like my primary care physician, referring physician, psychologist, and/or physical therapist, unless I request in writing that Dr. Chester may not discuss my medical care with certain individuals. Our office will never share, sell, or rent your personal information to anyone for marketing purposes.

\_\_\_\_\_  
Printed Name of Patient

 \_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Today's Date

If you are accepted into the medical practice, you will be asked to present an original, current, government issued photo ID card and your insurance card(s) for verification.

# PATIENT INITIAL EVALUATION SURVEY

⬆ Last Name First Name Middle Initial Age Today's Date

What medical condition would you like Dr. Chester to evaluate? \_\_\_\_\_

Did someone refer you to our office? \_\_\_\_\_

Have you seen another doctor for this condition?  No  Yes, their name is \_\_\_\_\_

Have you had any previous treatments for your current condition? Please check all that apply.

- No     Medical     Physical Therapy     Chiropractic  
 Massage     Acupuncture     Psychology     Other \_\_\_\_\_

Have you had any X-Rays, MRIs, nerve testing, blood tests, or other tests for your current condition?

- No     Yes, I have had \_\_\_\_\_

**List each body part which has pain. If you would like to be seen for addiction treatment only, you may skip this section.**

**BODY PART 1:** \_\_\_\_\_  Pain is constant     Pain comes & goes: how often? \_\_\_\_\_  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
no pain                                  mild                                  moderate                                  severe                                  worst pain  
I can imagine

**BODY PART 2:** \_\_\_\_\_  Pain is constant     Pain comes & goes: how often? \_\_\_\_\_  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
no pain                                  mild                                  moderate                                  severe                                  worst pain  
I can imagine

**BODY PART 3:** \_\_\_\_\_  Pain is constant     Pain comes & goes: how often? \_\_\_\_\_  
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
no pain                                  mild                                  moderate                                  severe                                  worst pain  
I can imagine

**Do you have problems with any of the following? Please check all that apply.**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> sitting                           | <input type="checkbox"/> reaching            | <input type="checkbox"/> grooming         | <input type="checkbox"/> taking care of another person |
| <input type="checkbox"/> standing                          | <input type="checkbox"/> gripping            | <input type="checkbox"/> using the toilet | <input type="checkbox"/> sports/hobbies                |
| <input type="checkbox"/> walking                           | <input type="checkbox"/> lifting             | <input type="checkbox"/> cooking          | <input type="checkbox"/> sexual activity               |
| <input type="checkbox"/> running                           | <input type="checkbox"/> carrying            | <input type="checkbox"/> cleaning         | <input type="checkbox"/> learning                      |
| <input type="checkbox"/> bending                           | <input type="checkbox"/> writing             | <input type="checkbox"/> household chores | <input type="checkbox"/> thinking                      |
| <input type="checkbox"/> stooping/squatting                | <input type="checkbox"/> typing/computer use | <input type="checkbox"/> driving          | <input type="checkbox"/> reasoning                     |
| <input type="checkbox"/> twisting                          | <input type="checkbox"/> using arms          | <input type="checkbox"/> shopping         | <input type="checkbox"/> concentration                 |
| <input type="checkbox"/> getting to or from a bed or chair | <input type="checkbox"/> dressing            | <input type="checkbox"/> sleeping         | <input type="checkbox"/> socializing                   |

**Do you have any of the following? Please check all that apply.**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> numbness/tingling: _____ | <input type="checkbox"/> sexual dysfunction  | <input type="checkbox"/> stiffness of joints: _____ | <input type="checkbox"/> chest pain                |
| <input type="checkbox"/> new weakness: _____      | <input type="checkbox"/> black/bloody stools | <input type="checkbox"/> swelling of joints: _____  | <input type="checkbox"/> cough                     |
| <input type="checkbox"/> falls/clumsiness         | <input type="checkbox"/> diarrhea            | <input type="checkbox"/> swollen ankles             | <input type="checkbox"/> shortness of breath       |
| <input type="checkbox"/> recent cold/flu          | <input type="checkbox"/> heartburn/nausea    | <input type="checkbox"/> leg cramps                 | <input type="checkbox"/> headaches                 |
| <input type="checkbox"/> fevers                   | <input type="checkbox"/> painful urination   | <input type="checkbox"/> swollen glands             | <input type="checkbox"/> difficulty swallowing     |
| <input type="checkbox"/> chills                   | <input type="checkbox"/> frequent urination  | <input type="checkbox"/> change in vision           | <input type="checkbox"/> itching/rash/skin changes |
| <input type="checkbox"/> night sweats             | <input type="checkbox"/> other problems with | <input type="checkbox"/> change in hearing          | <input type="checkbox"/> nail/hair changes         |
| <input type="checkbox"/> unplanned weight loss    | bowels/bladder                               | <input type="checkbox"/> change in taste            | <input type="checkbox"/> fatigue/tiredness         |
| <input type="checkbox"/> pain that wakes you up   | <input type="checkbox"/> fainting/blackouts  | <input type="checkbox"/> change in smell            | <input type="checkbox"/> depressed mood            |
| <input type="checkbox"/> trouble sleeping         | <input type="checkbox"/> lack of appetite    | <input type="checkbox"/> change in speech           | <input type="checkbox"/> anxiety/nervousness       |

**Do you have any of the following? Please check all that apply.**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> surgery: _____              | <input type="checkbox"/> foot problems                          | <input type="checkbox"/> miscarriage                   |
| _____  | <input type="checkbox"/> head injury                            | <input type="checkbox"/> sexually transmitted diseases |
| <input type="checkbox"/> heart disease               | <input type="checkbox"/> eye problems                           | <input type="checkbox"/> back pain                     |
| <input type="checkbox"/> diabetes                    | <input type="checkbox"/> skin problems                          | <input type="checkbox"/> nerve / spinal cord problem   |
| <input type="checkbox"/> high / low blood pressure   | <input type="checkbox"/> exposure to chemicals / sun / asbestos | <input type="checkbox"/> scoliosis                     |
| <input type="checkbox"/> high cholesterol            | <input type="checkbox"/> ulcer                                  | <input type="checkbox"/> multiple sclerosis            |
| <input type="checkbox"/> anemia/low blood count      | <input type="checkbox"/> stomach / intestine problems           | <input type="checkbox"/> Parkinson's disease           |
| <input type="checkbox"/> bleeding problems           | <input type="checkbox"/> liver problems / jaundice              | <input type="checkbox"/> seizures                      |
| <input type="checkbox"/> lung disease / tuberculosis | <input type="checkbox"/> kidney stones / kidney disease         | <input type="checkbox"/> stroke                        |
| <input type="checkbox"/> cancer: _____               | <input type="checkbox"/> bladder/urine problem                  | <input type="checkbox"/> aneurysm                      |
| <input type="checkbox"/> bone disease                | <input type="checkbox"/> prostate problem                       | <input type="checkbox"/> childhood diseases            |
| <input type="checkbox"/> fractures: _____            | <input type="checkbox"/> testicular disease / removal           | <input type="checkbox"/> child abuse                   |
| <input type="checkbox"/> joint dislocation: _____    | <input type="checkbox"/> ovarian disease / removal              | <input type="checkbox"/> depression                    |
| <input type="checkbox"/> arthritis: _____            | <input type="checkbox"/> uterine disease / removal              | <input type="checkbox"/> anxiety disorder              |
| <input type="checkbox"/> thyroid problem             | <input type="checkbox"/> breast disease / removal               | <input type="checkbox"/> other mental illness          |
| <input type="checkbox"/> hormone problem             | <input type="checkbox"/> HIV / AIDS                             | <input type="checkbox"/> other injury / trauma         |
| <input type="checkbox"/> poor circulation            | <input type="checkbox"/> addiction: _____                       | <input type="checkbox"/> other: _____                  |

**What are your current medicines and their dosages (include prescription, over-the-counter, supplements, oral contraceptives, and hormone replacement):**

- I am not currently taking any medications.
- I am taking the following medications, supplements, and/or vitamins: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Do you have any allergies? Please include medicines, food, seasonal, other.**

- No  Yes, \_\_\_\_\_

Approx. Height \_\_\_\_\_ ft \_\_\_\_\_ in      Approx. Weight \_\_\_\_\_ lbs

For Women: To the best of your knowledge, could you be pregnant?  No  Yes (please inform Dr. Chester when you see him.)

Do you chew or smoke tobacco? e-cigs? vape?  No  Yes (what? how many? how often?) \_\_\_\_\_

Do you drink alcohol (beer, wine, liquor)?  No  Yes (what? how much? how often?) \_\_\_\_\_

Do you use any illegal or illicit drugs?  No  Yes (what? how much? how often?) \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Who do you live with? \_\_\_\_\_

Are you working?  No  Yes - your occupation / job: \_\_\_\_\_

Full-time  Part-time      Regular Duties?  Yes  No

Name of your primary care physician (PCP): \_\_\_\_\_

**Do any of the following diseases run in your family (parents, brothers, sisters, children)? Please check all that apply.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> heart disease       | <input type="checkbox"/> kidney stones / kidney disease | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> ovarian disease/removal    |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> thyroid problem                | <input type="checkbox"/> liver disease      | <input type="checkbox"/> uterine disease/removal    |
| <input type="checkbox"/> lung disease        | <input type="checkbox"/> hormone problems               | <input type="checkbox"/> skin disease       | <input type="checkbox"/> breast disease/removal     |
| <input type="checkbox"/> arthritis           | <input type="checkbox"/> stroke                         | <input type="checkbox"/> addiction          | <input type="checkbox"/> testicular disease/removal |
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> bone disease                   | <input type="checkbox"/> anxiety            | <input type="checkbox"/> other: _____               |
| <input type="checkbox"/> cancer: _____       | <input type="checkbox"/> stomach/intestinal disease     | <input type="checkbox"/> depression         |   |

**INSTRUCTIONS: YOU MUST COMPLETE THIS PAGE. PLEASE READ EACH SECTION AND ANSWER THE QUESTIONS. THEN SIGN AND DATE THE BOTTOM OF THIS PAGE.**

**SECTION 1: IS YOUR CONDITION DUE TO A WORK-RELATED INJURY?**

NO (If you answered "NO," please continue to Section 2 of this form)

YES, Date of work-related injury \_\_\_\_\_ Time of injury \_\_\_\_\_ am / pm

Did your injury happen in Hawaii?  Yes  No Date supervisor was notified of injury \_\_\_\_\_

Date you last worked \_\_\_\_\_ Supervisor's name: \_\_\_\_\_

Briefly describe how injury occurred, and which body parts were injured: \_\_\_\_\_

Any other work-related injuries?  No  Yes: \_\_\_\_\_

**SECTION 2: IS YOUR CONDITION DUE TO A MOTOR VEHICLE ACCIDENT?**

NO (If you answered "NO," please continue to Section 3 of this form)

YES, Date of motor vehicle accident \_\_\_\_\_ Time of accident \_\_\_\_\_ am / pm

Did your accident happen in Hawaii?  Yes  No

Briefly describe how accident happened: \_\_\_\_\_

Were you the  driver?  passenger?

Were you wearing your seat belt? .....  No  Yes

Did the air bags deploy?.....  No  Yes

Was the vehicle damaged? .....  No  Yes (what part of the car), \_\_\_\_\_

Did you hit your head? .....  No  Yes

Did you brace yourself? .....  No  Yes

Did you go to the Emergency Room (ER)? .....  No  Yes

If "yes," were x-rays taken? .....  No  Yes

If "yes," were blood tests done? .....  No  Yes

If "yes," were you given medication? .....  No  Yes, \_\_\_\_\_

Do you have nightmares about the accident? .....  No  Yes

Are you nervous about driving?.....  No  Yes

Are you nervous about being a passenger? .....  No  Yes

Any other motor vehicle accidents?.....  No  Yes (date, where & what happened), \_\_\_\_\_

**SECTION 3 - IS YOUR CONDITION DUE TO AN INJURY WHICH HAPPENED IN A PRIVATELY OWNED LOCATION?** For example, you slipped and fell in a restaurant, supermarket, or mall parking lot?

NO (If you answered "NO," please sign and date the bottom of this form)

YES, Date of injury \_\_\_\_\_ Time of injury \_\_\_\_\_ am/pm

Did this accident happen in Hawaii?  Yes  No

Briefly describe how injury occurred: \_\_\_\_\_

**IF YOU ANSWERED "YES" TO ANY OF THE SECTIONS ABOVE, PLEASE ANSWER THE FOLLOWING...**

What is the status of your claim?  Open  Closed  Settled w/Medical Open  Funds Exhausted  Pending  Denied  I Don't Know

Do you have an attorney or lawyer for your claim?  No  Yes, their name is \_\_\_\_\_

 \_\_\_\_\_ Patient's Signature      Patient's Name Printed      Today's Date

1063 Lower Main St, Ste C212  
Wailuku, HI 96793-6006  
www.ponohealthcare.com

### JEFFREY H. CHESTER, DO

Board Certified by American Board of Physical Medicine & Rehabilitation  
Board Certified by American Society of Addiction Medicine

Phone 808.249.8887  
Fax 808.249.8889  
drchester@ponohealthcare.com

Physiatry/Pain Management/Electrodiagnostic Medicine/EMG/Osteopathic Manual Medicine/Addiction Treatment

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_, authorize  
Patient's Name Birth date Social Security Number

~~JEFFREY H. CHESTER, DO~~ OR  Name of Physician/Person/Organization authorized to release information to Jeffrey H. Chester, DO

\_\_\_\_\_  
Name of Physician or Medical Organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City / State / Zip Code

\_\_\_\_\_  
Phone Number Fax Number

To release the following medical records / information:

THREE (3) MOST RECENT OFFICE VISIT NOTES; Diagnostic reports and Lab results from one year

Release information to: Dr. Jeffrey H. Chester, DO

**Please fax records if less than 20 pages.**

Address: 1063 Lower Main St, Ste C212

**Please mail records if more than 20 pages.**

City/State/Zip: Wailuku, Hawaii 96793-6006

Phone / Fax: 808.249.8887 / 808.249.8889

Release of information is for the purpose of (*check one*):  Continued care  Other: \_\_\_\_\_

Check one:  I consent...  I do not consent...

...to the release of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) for Dr. Chester to review.

- 1) This consent shall be valid for six (6) months from the date of the signing, unless revoked.
- 2) My permission is extended only for the purpose stated on this authorization.
- 3) If applicable, I understand that I will be responsible for any charges incurred for this service. \_\_\_\_\_

initial

\_\_\_\_\_  
Signature of Patient or Patient's Guardian

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Phone Number



**INSTRUCTIONS: Complete this form if you have any type of Medicare insurance (examples: Medicare A/B, Humana, UnitedHealthcare, HMSA 65C+, HMSA Senior Advantage, Kaiser Senior Advantage)**

**Medicare Private Contract Form**

This agreement is between Dr. Jeffrey H. Chester, DO ("Physician"), whose principal place of business is 1063 Lower Main Street, Suite C212, Wailuku, Hawaii 96793, and patient (print name) \_\_\_\_\_

("Patient"), who resides at \_\_\_\_\_

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician opted out of the Medicare program effective January 01, 2013, and continues to opt out of Medicare programs, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"): Consultation appointment, Re-evaluation appointment, Osteopathic Manual Therapy, Injection, and/or Electrodiagnostic Medicine/Nerve Conduction Study.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Selfpay Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges they have a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to them.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or their beneficiaries.

Executed on [Date] \_\_\_\_\_ between Dr. Jeffrey H. Chester, DO and

[Patient name] \_\_\_\_\_

[Patient signature] \_\_\_\_\_

[Physician signature] \_\_\_\_\_

**INSTRUCTIONS: Complete this form if our office does not participate with your medical insurance, or if you do not have any medical insurance.**

**FINANCIAL POLICY – SELFPAY/PRIVATE PAY FORM**

In order to ensure the highest quality service and medical care to our patients, Dr. Chester’s medical practice does not overbook or schedule walk-in appointments. This means if you do not arrive on-time for your scheduled appointment, do not show up, or cancel/reschedule without at least 24 hours’ notice, there is an unplanned opening in our schedule. **For these reasons, our office requires pre-payment for your initial office visit before reserving a date and time for your appointment.**

An initial medical evaluation with Dr. Chester is \$365.00, due in-full prior to the initial visit. Follow-up office evaluations with Dr. Chester are \$215.00, due in-full on the date of the visit.


By signing below, I understand that if I am accepted into Dr. Chester’s medical practice, I acknowledge all of the above and I accept the charges associated with my office visits with Dr. Jeffrey H. Chester.

If I am accepted into Dr. Chester’s medical practice, I will call your office to find out the best day/time for me to make my pre-payment in-person, with my MasterCard, VISA or cash (no checks). I understand that Dr. Chester’s office will schedule my initial appointment once my payment is processed.

-----

Once your non-refundable pre-payment is successfully processed, you will have an appointment scheduled for a medical evaluation with Dr. Chester. Please note that if you do not show up for your appointment, are more than 15-minutes late, or do not re-schedule with at least 24 hours’ notice, a \$100 fee will be assessed to your account which must be re-paid prior to re-scheduling your appointment. *A copy of this completed document will be provided to you at your initial office visit and become a written receipt for your records.*

Print your name: \_\_\_\_\_

 \_\_\_\_\_  
Your signature acknowledging all of the above Date

**Below To Be Completed By Dr. Chester's Office:**

Date payment processed: \_\_\_\_\_ Processed by: \_\_\_\_\_

Copy to Patient

Appointment scheduled for: \_\_\_\_\_ at \_\_\_\_\_ am / pm