



## Doctor-Patient Partnership Agreement

We are delighted that you chose to partner with Blum Center for Health to guide you in your wellness plan. In order to successfully realize your goals, it is essential that we collaborate with the shared intention of achieving optimal health. Please read below, sign, and return back to start the journey together!

### As your health partner, we agree:

- To keep your information confidential and secure by adhering to HIPAA standards and policies.
- To respect your time by being on schedule as much as possible, barring any unavoidable circumstances. In that instance, you will still have your full time with your practitioner.
- To provide you with a safe and positive setting to share your goals, intentions, and any concerns.
- To provide you with a clear, concise, and comprehensive treatment plan including education, protocols, testing, referrals, recommendations, etc.
- To do our best to ensure that any blood panel ordered with your in-network lab is covered by your insurance. However, depending on the nuances of your plan, this is not guaranteed. Prior to your blood draw, we highly recommend checking with your insurance company for specific coverage.

### As our patient, you agree:

- To complete our new patient intake forms and return, along with any recent/relevant records, prior to your appointment.
- To arrive 15 minutes ahead of your appointment time to allow ample time for check-in.
- To be open to exploring non-conventional testing and protocols to uncover the root of your issues.
- To check with your insurance company for specific coverage of ALL testing ordered by our office before having the testing done. All lab results will be reviewed with your practitioner at the follow-up visit.
- To share any concerns regarding your treatment, care, or any suggestions you may have that would improve your experience with us.
- To respect the practitioner’s calendar by adhering to our Change/Cancellation Policy:
  - 5-business days’ notice for initial appointments
  - 3-business days’ notice for follow-ups

*We reserve the right to charge your credit card 50% of your scheduled visit, if the appointment is not canceled or rescheduled within the guidelines of our policy.*

*Please provide your credit card information to confirm your appointment. We accept Visa, MasterCard and American Express. You have the option of using another form of payment for your visits at the time service is rendered.*

Name on Card: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Exp: \_\_\_\_/\_\_\_\_ CVV Code: \_\_\_\_\_

*By signing below, you accept the terms of our cancellation/rescheduling policy:*

Patient Name/Signature: \_\_\_\_\_

Parent/Guardian Signature (under 17 years of age): \_\_\_\_\_

In Good Health,  
Susan S. Blum, MD, MPH, Medical Director

*I have read and accept the terms of this agreement:*

Name: \_\_\_\_\_ Date: \_\_\_\_\_