Amy K. Davis, MD

Welcome to Crossing Back to Health, thank you for trusting us to assist you with your healthcare needs. Enclosed you will find information about our clinic and general office policies.

Pre-Visit Preparation:

1. Create an account at www.XB2H.com
2. A photo ID along with your Insurance card will be needed if labs are ordered
3. Please read and sign the Financial Policy and Informed Consent that is enclosed

What to Expect at Your Initial Visit:

1. Detailed interview to review medical and developmental history, current concerns and symptoms
2. Physical examination
3. Discuss and order appropriate laboratory tests to aid medical decisions
4. An initial individualized treatment plan

Follow Up Visits May Include the Following:

1. Review of progress
2. Review and explanation of laboratory testing
3. Revision of treatment plan based on laboratory testing and clinical response
4. Evaluation for allergies, toxicities, and immune imbalances
5. Decide if any further testing is needed
6. Continue to target nutritional and supplemental support to your individualized needs

Suggestions to Make the Visit More Pleasant:

Although we strive to be efficient during your appointments, they can be lengthy. Your initial appointment will last approximately 2 hours so plan accordingly. The appointments tend to be long for children and they become hungry. Feel free to bring a snack. It's hard for them to be comfortable and cooperative when they are hungry.

Supplements:

At XB2H our Supplements are professional grade and are available to Crossing Back to Health's patients. You may purchase supplements at www.XB2H.com or at the office during office hours. Shipping is available Monday -Thursday. If orders are placed before noon they will be shipped same day.

Laboratory Testing:

Various laboratory tests may be ordered depending on the individual. We understand that you are anxious to know individual lab results as they return, however each of the labs give pieces to the puzzle and are interpreted in total. When labs are complete and reviewed by Dr. Davis, you will receive a call with recommendations if needed. All labs will be reviewed in depth at follow up appointment.

Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy which will apply to ALL appointments and consultations. Please read it carefully and sign acknowledging your understanding and acceptance of these policies.

- **Payment for appointments must be paid in full at time of service.**
- MasterCard, Visa, and Discover, cash and checks are accepted.
- **Please note that we do not file for insurance.** However, we do provide a copy of your "paid" Superbill with diagnostic/procedure codes if you choose to submit for
    - reimbursement from your insurance company. Please be aware that some, and perhaps all, of the services provided may be "non-covered" services. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.
- **Insurance companies that require additional information create an added burden and expense to our office.** Charges for additional information include: Copies: $0.50 per page, Short insurance form: $15.00, Long insurance form: $25.00, Letter of Medical Necessity:
- $40.00, or a Narrative Report: $100-$250. We will send out the information when the necessary fees are paid.
- **Fee Summary:** Services including follow-up visits and phone consults are billed based on time spent. The charge is $300.00 an hour and increases by 15-minute increments. The charge for a Zyto remote appointment is $350.00 an hour and increases by 15-minute increments.
- **CANCELLATION POLICY:** Because we offer specialized services, we only see a limited number of patients per day. When clients do not show up or cancel for non- emergency reasons, it takes valuable time away from those clients on our waiting list. With adequate notice of cancellation we are often able to schedule those clients on our waiting list.
    - We require 1 weeks' notice of cancellation for new patient appointments and 2 business days cancellation for follow up appointments. If canceling appointment within the cancellation time or "no show" you will be charged $300.00. When rescheduling you will receive
    - $150.00 credit for future appointment. Monday appointments must be cancelled on the preceding Wednesday to avoid charges since we are not in the office on Fridays.
- **Cancellations for emergency reasons are excluded from the above policy but will need to be placed on the schedule for a future appointment at the time of cancellation.**
- **Payment is due at time of service. There will be a 25.00 fee for returned checks.**

We appreciate your understanding the need for this financial policy. Please feel free to ask any questions you may have.

I have read this financial policy and agree to all it entails.

____ ***Date***__________
Signature Patient/Responsible Party

Crossing Back to Health
485 Wildwood Parkway #2, Ballwin, MO 63011
Phone: (636) 778-9158 Fax: (636) 778-9162 E-mail: answers@crossingbacktohealth.com
Web: www.crossingbacktohealth.com

Patient Profile

First Name: ____

Middle Name: ____

Last Name: ____

Birth Month: ___________________________________

Birth Day: _____________________________________

Birth Year: ____________________________________

Social Security Number: __________________________

Place of Birth, City, State, Country: __________________

Sex: *Male* / *Female* Age: Years _____ Months _____

Who referred you to our clinic? ____

Primary Care Provider: ____

Insurance Company: ____

Allergies to Medications: ____

Home Address: ____________________________________

City: ____

State: ____

Zip Code: _______________________________________

Email Address: ___________________________________

Home Phone: _____________________________________

Cell Phone: ______________________________________

Emergency Contact and Phone Number: ____

Patient Profile Continued

If client is a minor, Mother's Name: ___________________

Mother's Occupation: ________________________________

Mother's Work Phone: ________________________________

If client is a minor, Father's Name: ___________________

Father's Occupation: ________________________________

Father's Work Phone: ________________________________

Patient / Parent Signature: ____

Today's Date: ___________________________

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Informed Consent

You have the right to be fully informed about your health and any decisions affecting your care and well-being. This consent is to ensure you are informed about your healthcare at Crossing Back to Health.

Because we are often dealing with challenging disorders in which the traditional standard of care has failed to resolve the problem, we utilize nontraditional and integrative treatment strategies, as well as traditional approaches. We attempt to find new, effective, affordable and creative ways to arrest the progression of acute/chronic disease states, reverse acute/chronic symptoms and to optimize health through restorative and preventative practices. These may include, but are not limited to the use of nutraceuticals, botanicals, herbs, homeopathic, electrical stimulation, LED, ultrasound, infrared sauna, acupuncture, and bioenergetic testing. These methods are innovative and often go beyond the established standard of care seen in traditional medical practice.

I understand that medical diagnosis and treatment is not an exact science and that I expect the Health Professionals at Crossing Back to Health to make judgments in my best interest based on the facts as known to them at the time. I also acknowledge that no guarantees or assurances have been made concerning the outcomes from these treatments.

My signature on this form acknowledges my receipt of this information and gives my consent for treatment. I have had the opportunity to discuss with clinic personnel the nature of the treatment, to ask questions and have them answered to my satisfaction. This consent covers the entire course of treatment today and for any future conditions for which I seek treatment.

To be completed by patient:

____
Patient Name

____
Signature of Patient or Legal Guardian

To be completed by doctor or staff:

____
Witness to patient's signature

____
Date Signed

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Consent to Release Minor Patient Information

I,________________________, parent of______________________, hereby authorize Crossing Back to Health to discuss my minor child's medical treatment including test results with.

Name____ Date_____________

Name____ Date_____________

Name____ Date_____________

It is OK to leave a message

- ☐ At home _________________________
- ☐ At work _________________________
- ☐ On cell phone _____________________

Parent Name______________________________________ Date_____________

I understand that it is my responsibility to inform Crossing Back to Health of any changes.

Consent to Release Patient Information

I,______________________________, hereby authorize Crossing Back to Health to discuss my medical treatment including test results with.

Name____ Date_____________

Name____ Date_____________

Name____ Date_____________

It is OK to leave a message

- ☐ At home _________________________
- ☐ At work _________________________
- ☐ On cell phone _____________________

Patient Name____ Date_____________

I understand that it is my responsibility to inform Crossing Back to Health of any changes.

3/8/2011

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