Integrative Medical Center of New Mexico, PC
Burton M. Berkson, MD, Ph.D. & Arthur J. Berkson, MD
1155 Commerce Dr. Ste. C, Las Cruces, NM 88011

The philosophy of Integrative Medical Center is that good health is advanced through self-awareness, healthy diet, moderate exercise and a healthy lifestyle.

I, _____ , understand that Dr. Berkson is an **office-based** medical doctor who makes a great effort to keep the patient healthy. Office-based is defined as a physician whose practice is solely performed in the clinic setting.

I understand that *Dr. Arthur Berkson* provides primary care to local adults as well as integrative medical consultations. If his primary care patients should require hospitalization he uses the services of hospitalist specialists at either of the two local hospitals. If I am under the care of *Dr. Burt Berkson*, I understand that **I should also have a primary care physician**. If I do not have such a doctor, Dr. Berkson will suggest one and if hospitalization is necessary, Dr. Berkson will refer me to a hospitalist for admission.

I understand that Dr. Berkson's practice is based on the cooperation of the doctor and the patient in the effort to promote good health. **The outcomes are partially based on the individual patient's response to and compliance with the program.**

I understand that in cases of medical emergency, I should call 911 or go immediately to the emergency room. For non-emergency issues, Dr. Berkson will make every reasonable effort to see me in the office within 24 hours after a phone call during regular office hours.

I understand that my personal medical health information is confidential and will only be used for treatment, payment, and healthcare operations. All personal medical health information is safeguarded per HIPAA regulations.

Data may be used anonymously as part of a published study: _____*please initial*

I understand that prescriptions will be refilled during regular office hours. **(It is recommended that you call for refills when you still have at least one week's worth of medication left.)**

I understand that while IMC may file my insurance claims for me, payment is expected at the time of the visit.

I understand that IV therapy is NOT covered by any insurance and will NOT be billed to my carrier. _____ *please initial*

I further understand that Medicare and other insurance carriers may NOT pay for some treatments during an office visit. I understand there is a $50 charge for any appointment cancelled without at least a 24-hour notice. Costs for the non-covered items are available upon request and prior to any treatment given.

I, the undersigned, recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim.

I, by my signature below, have been informed that ANY SUPPLEMENTS or other medication purchased in this office will NOT be covered by my insurance or Medicare.

I understand that the term "Initial Visit" means the first 45 minutes of my initial appointment. Any additional time past the first 45 minutes of my Initial Visit will incur an additional charge.

By my signature, I acknowledge to having read, or having read to me, the contents of this paper and accept the condition and restrictions noted within.

Patient signature: _____ Date: _____

Witness signature: _____ Date: _____