

TERMS AND AGREEMENTS

Rose Clinic, A Professional Medical Corp.
530 Lomas Santa Fe Drive Suite B-1 Solana Beach, CA 92075
Phone: 858-755-8955 Fax: 858-755-8959
www.roseclinic.us

(Please Print)

TERMS AND AGREEMENTS

When scheduling an appointment, please log on to www.rose-clinic.com and click on make an appointment online or call 858.755.8955. If you are a new patient scheduling services, complete the patient forms by clicking on patient information then complete the patient forms.

Complete the following forms for services:

Initial consult - medical questionnaire
Breast Ultrasound – breast imaging form
Nutritional consult – nutrition information form
Prescription appointment – new patient information form
Thermography - new patient form

To schedule an appointment, a credit card needs to be on file, and patient paper work completed. To complete the credit card authorization form, go to www.rose-clinic.com and click on patient information -> credit card authorization.

Initial paperwork must be completed and provided to our office no later than 2 business days prior to the first appointment. You may fax or email these forms but the originals must be delivered at the appointment time.

The cancellation policy requires a cancellation to be made within 48 hours or there will be charge of \$ 150.00.

Rose Clinic, A Professional Medical Corporation does not courtesy bill to insurance companies. For all appointments payment is due in full. Rose Clinic can provide CPT and diagnostic codes as a courtesy, so the patient can forward medical claims to respective insurance companies. Rose Clinic is not a contracted provider to any insurance companies. HMO insurance will not cover insurance services out of their own network.

I accept my medical information may be disclosed under federal and state law.

I hereby authorize payment directly to Dr. Jeanne Stryker for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Dr. Jeanne Stryker and/ or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature:

Date

Print Name:

Date

Reviewed by:

Date