South Carolina
Center for Integrative Medicine

Decision to Join: I acknowledge and understand that I am voluntarily becoming a member of South Carolina Center for Integrative Medicine (herein "SCCIM") and that this agreement is non--transferable. The effective date of my SCCIM membership is the date on which I sign this document. I have reviewed the services provided by SCCIM and have had the opportunity to ask questions and receive answers regarding those services. __________

Consent to treat: Treatment includes but is not limited to**:** Interview (history taking), Physical examination, and common diagnostic procedures such as blood pressure, pulse ox, urine tests, etc. The administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of the member, including but not limited to diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of SCCIM's providers may be considered medically necessary or advisable.

I acknowledge and understand that this consent is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy or electronic copy of this consent shall be considered as valid as the original.

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Insurance: I acknowledge and understand that this agreement **does not** provide comprehensive health insurance coverage, nor is it a contract of insurance, and that it only provides access to the health care services specifically provided by SCCIM for the single low cost monthly fee. I understand that SCCIM strongly recommends that I maintain health insurance for services not provided by this agreement to cover unpredictable or catastrophic expenses or medical services beyond the scope of those provided by SCCIM.

I also acknowledge and understand that SCCIM will attempt to file for additional reimbursement from my private insurance provider but that I am responsible for any payments due at the time of any services. __________

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Columbia, SC 29210
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What is not included: Membership benefits do not include any services provided by other health care providers, institutions, or organizations. Specialist care, including OB, surgery, emergency department visits or emergency services, imaging, non--clinic lab testing, and medications are also not included. __________

Charge Responsibility: I understand and accept that I am responsible for all charges incurred for health care services provided by SCCIM. I acknowledge and understand that I am responsible for any charges incurred for services outside of SCCIM, including but not limited to emergency department visits, hospital and specialist care, imaging and laboratory tests, equipment and medications. __________

Billing Details: I acknowledge that the membership fee of $25/month per person with a family cap of $100/month is due on the 25th of each month and applies to the period of the 25th of the previous month through the 24th of the month in which the charge is applied. The charges occur at the end of each month's services. In addition to the monthly membership fee, I acknowledge and agree to pay established charges related to sick/emergency visits, skilled nursing, follow up visits, NAET visits, Health Coaching visits, copies of medical records, returned checks and other administrative and compensatory fees. These are available on request and are subject to change without notice. __________

Late Payments: If I am unable to pay my bill at the time of billing, I understand that I will be charged a $30 late fee for each late payment. Members who miss payment for two (2) consecutive months will be terminated from the membership service agreement and will have to wait nine (9) months to reinstate their membership or pay an additional $100 reinstatement fee. As SCCIM grows and adjusts to the needs of patients and the health care environment, it is possible that we will need to make changes to our services and fees. SCCIM reserves the right to change (add or discontinue) services or change the fee schedule at any time. Members will receive written notice prior to changes taking effect. __________

No Show Fees: All cancellations must be completed at least 24 hours prior to your appointment. If you do not show up for an appointment or are significantly late to the appointment, you may be charged a $25 fee for a missed visit. Exceptions to this fee may be granted at our discretion. __________

Termination: I acknowledge that membership in SCCIM is designed and intended to be continuous, though members may terminate their membership at any time. If a member

terminates their membership, they will have to wait nine (9) months to reinstate their membership or pay $100 reinstatement fee. SCCIM will reimburse members any fees collected in advance for the months following termination of membership. Please request the termination in writing, with at least a five (5) days' notice before the next payment. SCCIM does not offer prorated refunds for partial months. I acknowledge and understand that SCCIM may terminate my membership by providing me thirty (30) days written notice in accordance with the laws of the State of South Carolina. SCCIM will not terminate the membership agreement based on health condition or protected status. ___________

This is a private letter of agreement between SCCIM and you/your family. This letter (signed by each responsible party) and attached list of household members signed by the household's financially responsible person constitutes the full terms of your membership.

Accepted By:

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Signature of Patient (Responsible party) Date

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Printed name of patient

Name of Family Member	Date of Birth

When you have filled in the form, please print as a .pdf and then submit to frontdesk@sccimed.org.

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