Financial Agreement

Self-Pay

I,______________________________understand that the Stram Center medical staff are non-participating with my current insurance plan carrier and therefore accept responsibility for payment of services at the time service is rendered. Furthermore, I understand that my current insurance plan will not be billed on my behalf for fees paid.
In the event that you need assistance in dealing with reimbursement issues with your insurance company, please contact the Health Care Bureau of the NYS Attorney General at 1-800-428-9071. For additional resources, please call Healthcare Advocates, Inc. at (215)-735-7711, or visit their website: www.healthcareadvocates.com.

If you have Medicare as a primary insurance please notify our office prior to your scheduled appointment. A private pay contract must be signed by any Medicare Beneficiary in order to be seen in our office by Dr. Stram or his staff, as we are non-participants with Medicare.

Financial Statement: As a Stram Center patient, I understand that I am responsible for the payment of services received. I agree to keep my account current and will pay at the time of service. I will notify the office 72 business hours in advance if a cancellation or reschedule is necessary, otherwise I agree to be responsible for a missed appointment charge or forfeiting my initial new patient scheduling fee.

If you are unable to keep your scheduled appointment, please notify our office at least 72 business hours in advance so that we can accommodate our other patients with a vacant appointment. For continuity of care it is recommended that you reschedule your appointment at that time. Failure to provide our office with 72 business hour notification will incur a missed appointment fee and/or loss of deposit. Being more than 15 minutes late may result in the need to reschedule your appointment.

Patient Name:____

Signature:____

Date:___________________________________

MEDICINARY DISCLAIMER

I,______________________________, fully understand that the statements and treatment plan regarding supplements discussed with me by the Stram Center Medical staff may not have been evaluated by the FDA. Some of the supplements recommended are to support the body's system functions. There may be adverse effects and contraindications to any one of these supplements that are recommended. These products are not intended to diagnose, treat, cure or prevent any disease.

The Stram Center Medical staff does not claim that any or all of the products suggested will stimulate, maintain, regulate or promote structure of the body or restore normal or correct abnormal function. I also understand that I am not obligated to buy any or all supplements at this location. I am free to obtain them from other sources if available, but further understand the Stram Center cannot guarantee the efficacy of supplements from outside sources, which may impact treatment.

Patient Name:____

Signature:____

Date:_________________________________

Ronald L. Stram, MD, Founder, Medical Director

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Stram Center Therapeutic Agreements and Confidentiality Statement.

As a Stram Center practitioner, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of the people who I work with. I believe it is my responsibility to:

- Assess each person's situation based on the information they provide
- Assist them to sort through their health-related challenges
- Provide information and options about treatment modalities that are available
- Support them to make conscious decisions regarding their health
- Develop, implement and support a plan of care that will promote physical, mental and spiritual health
- Evaluate the effectiveness of a plan of care
- Make referrals to community resources as appropriate

As a Stram Center patient, I agree to use my knowledge, skill and experience to the best of my ability in the best interest of my own physical, mental and spiritual health. I believe it is my responsibility to:

- Provide my Stram Center practitioner(s) with information that is relevant to my health
- Be willing to sort through my health-related challenges
- Ask questions related to treatment options and information that is provided. If supplements are mutually agreed as part of my treatment plan, take them only according to directions given to me and discontinue use if side effects ensue and report this to my Stram Center practitioner(s)
- Work together with my Stram Center practitioner(s) to develop a plan of care that incorporates goals that are meaningful to me and will promote my physical, mental and spiritual health
- Make conscious decisions to nurture intrinsic healing and promote balance in my life
- Evaluate the effectiveness of my plan of care
- Participate in all scheduled treatment sessions
- Abide by the office policies of the Stram Center

CONFIDENTIALITY STATEMENT

As a Stram Center patient, I understand that what I discuss with my Stram Center practitioner(s) will be treated confidentially in accordance with law and recognized professional standards. I understand that only I can give up my right to privacy by signing a release of information.

I understand that if my safety or the safety of someone else is at risk, my Stram Center practitioner(s) are legally obligated to respond by sharing this information with the appropriate resources. For example:

- Licensed Social Workers, Nurses and Physicians are mandated by New York State Law to report any suspicion of child abuse to the New York State Registry
- Inform someone close to the client if they feel the client might harm him/herself or anyone else

Stram Center practitioners believe that the concept of integrative medicine works best when Stram Center practitioner discuss their work in team meetings, peer review, and/or supervision.

This allows each client to benefit from the combined insight, knowledge, skill and experience of Stram Center practitioners and those who supervise them. I understand that discussions of this nature would not include identifying information beyond a "need to know" basis, and such discussions would have the same privilege of confidentiality as sessions with each individual practitioner.

STATEMENT REGARDING CRISIS MANAGEMENT AND EMERGENCY MEDICAL CARE:

I understand that the Stram Center for Integrative Medicine does not provide physical or mental health crisis management. I understand if I am experiencing a physical or mental health crisis I must obtain service that are appropriate to the type of crisis I am experiencing. If I am experiencing severe, acute symptoms or feel a life threatening illness I will call:

- 911
- My local hospital emergency room
- My local police or fire department
- Albany County Mobile Crisis Team 518-447-9650 (Mental or emotional distress)

Patient Name:________________________ **Signature:**______________________ **Date:**________

CANCELLATION POLICY for MEDICAL APPOINTMENTS

Please note that the Stram Center's cancellation policy is in place in order to make certain that all of our patients maintain continuity of care with their assigned practitioner, and to ensure that all of our patients have the ability to see their practitioner in a timely manner. It is our goal to provide the highest quality of care to our patients and in doing so, following up in a timely manner is necessary – last minute cancellations do not allow our practitioners to maximize their opportunity to follow up with their patients, nor allow patients waiting to be seen to be called in a timely manner

I ______________________, understand that if I am unable to keep my scheduled appointment, I will notify the Stram Center 72 business hours in advance so that an accommodation is able to be made for other patients with the vacant appointment. I understand that failure to provide the Stram Center with 72 business hours' notice, will result in a $100.00 cancellation fee (or loss of deposit) to be assessed. This fee must be made payable over the phone at the point of cancellation or within 10 days of receipt of mailed invoice. I further understand that my account must be brought into balance, prior to rescheduling a missed appointment.

Print Name:____

Signed:____

Date:______________________________

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Naturopathy Agreement

The Stram Center is an integrative medical practice and therefore you may see more than one of our medical staff professionals during the course of your treatment. In the case you are assessed by Dr. Korey DiRoma or Dr. Kirsten Carle, our naturopathic doctors, it is important to understand the information provided below.

Naturopathy is not regulated in the state of New York. While Dr. Korey DiRoma and Dr. Kirsten Carle are licensed as primary care providers in other states, such as Vermont, New York does not currently license naturopathic physicians and therefore sets state restrictions on naturopaths on diagnosis and treatment; in this state, they are permitted to function as healthcare counselors. Consequently, health insurance companies will not reimburse for naturopathic services in New York State. Patients requiring a medical diagnosis for health care reimbursements should seek the care of a clinician licensed by New York State. However, naturopathy is an excellent complement to the care offered by your traditional physician.

New York State regularly reviews licensure of naturopaths. To get involved and help become an advocate for licensing naturopathic doctors in New York, go to the website for the New York Association of Naturopathic Physicians: www.nyanp.org

I,____________________understand Naturopathic Doctors are not licensed in the state of New York, and therefore I cannot submit claims for these visits to my health insurance company. I understand that my visit with a naturopathic doctor in New York is an out of pocket expense.

I have been advised as well, that my flexible spending or health savings account may cover for these services, but would be my responsibility to inquire through my individual benefit plan.

Thank you for your compliance in this matter.

Patient Name:____

Signature:____

Date:___________________________________

Acupuncture Consent Form

Procedures

The following procedures may be used during treatments. By initialing in the spaces provided you are stating that you are aware of the risks and benefits of each method described. If you have questions regarding any treatment methods please ask your practitioner.

______ **Acupuncture** involves subcutaneous insertion of fine needles into predetermined points on the body. Acupuncture is relatively painless and uses pre-sterilized disposable needles. Side effects are minimal. They may include a small bruise/soreness at site of needle insertion or lightheadedness. Organ puncture, pneumothorax, vessel puncture, and infection around the needling sight have also been reported, but are very rare.

______ **Chinese Herbs** are a service offered separately from acupuncture services. The herbs used are tested for pesticide residue and heavy metals. Side effects from herbs are minimal and may include nausea, constipation, loose stools, or rash. Most Chinese herbs do not interfere with synthetic drugs and vice versa. Please inform your Chinese medicine practitioner of all prescription and over the counter medications you are taking. If you are taking prescribed medication, please inform your prescribing physician of the herbs that you will be taking before you begin taking them.

______ **Tui Na** is Chinese massage. Techniques vary from pushing and kneading along meridian pathways of the body, to pressure applied at specific points. In some cases, soreness and bruising may occur. Your practitioner will request feedback during this procedure, and will work within your boundaries of comfort.

______ **Cupping** involves use of plastic or glass "cups" that are applied to skin surface to create suction. Cupping is used to release "stagnation" and heat from the body. A bruise may develop where the cup was placed on the skin.

______ **Moxibustion** is the use of the herb mugwart (known as "ai ye" in mandarin Chinese) in order to warm areas of the body. It may be applied indirectly or directly on the skin. To avoid burns please inform your practitioner of the intensity of heat during treatments. Burns and scarring have been reported with the use of moxa, however they are infrequent in the United States.

______ **TDP Lamp** is used to warm areas of the body. Please inform your Chinese medicine practitioner of comfort of heat intensity during treatments. TDP lamps use infrared heat, which can cause temporary redness of the skin, and in rare cases can cause burns.

______ **Electro-acupuncture** is the electrical stimulation of acupuncture needles using a 9-volt battery operated unit that closely regulates the intensity and frequency of the stimulation. Over-stimulation may occur on rare occasions, and lead to muscle spasm. Please inform your practitioner of your comfort level during electro-stimulation.

As practitioners of traditional Chinese medicine, we assess and approach individuals based upon the principles of traditional Chinese medicine. We do not make medical diagnoses, and suggest that you consult your physician regarding the condition or conditions for which you are seeking treatment.

Informed Consent

I, the undersigned, am aware of the benefits and risks of acupuncture, Chinese herbs, tui na, cupping, moxibustion, TDP lamp, and electroacupuncture. I fully understand that there is no implied or stated guarantee of the effectiveness of a specific treatment or a series of treatments. I also do affirm that Rebecca Rice or Chris Reilly, Licensed Acupuncturist has advised me to consult a physician regarding the condition or conditions for which I am seeking treatment.

FOR COMMUNITY ACUPUNCTURE PATIENTS: I consent to being seen in a group setting, in which others may be within listening distance. I am aware that private sessions are available to me as well.

PATIENT'S SIGNATURE_____________________________________ DATE_________

ACUPUNCTURIST'S SIGNATURE____________________________DATE__________

Manual Therapy Consent Form

I, ____________________________________, agree that it is my choice to receive manual therapy at the Stram Center for Integrative Medicine. I am aware of the benefits and risks of massage and any other form of manual therapy and give my consent. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that manual therapy is not a substitute for medical care, medical examination or diagnosis. I will state all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I will participate fully and make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

Patient Name:____

Signature:____

Date:__________________________________

Informed Consent – Personal Training

I ___________________________ acknowledge that by signing this document, I have voluntarily chosen to participate in a program of physical exercise, which may include an evaluation, that can enhance the musculoskeletal and cardiorespiratory systems in conjunction with my treatment at the Stram Center. In signing this document, I acknowledge being informed of the possible strenuous nature of the program and the potential for unusual, but possible physiological results including, but not limited to, abnormal blood pressure, fainting, heart attack, injury or death.

I am aware that consultation with my primary care physician is recommended prior to initiating any exercise program. By signing this document, I assume all risk for my health and well-being and hold harmless of any responsibility, the instructor, facility or any persons involved with this program and testing procedures. I assume this risk and agree that my use of the exercise equipment shall, at all times, be at my own risk. I, on behalf of myself, my heirs and personal representatives, hereby knowingly and voluntarily agree to waive and release owner from any liability, loss, cost, damage, expense, claim or suit whatsoever for any and all injury, loss, illness, harm, cost, expense, claim, suit or damage resulting from or related to my use of the exercise equipment and facilities located therein. I understand that questions about exercise procedures and recommendations are encouraged.

I have received and read a copy of the current rules and regulations governing the use and hours of operation of the exercise equipment and facilities located therein, a copy of which is attached hereto, and I shall fully comply with all such rules and regulations, as they may be amended from time to time.

Patient Name:____

Signature:____

Date:__________________________________

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Stram Center
for Integrative Medicine

Terms of Use: Email

The Stram Center for Integrative Medicine offers our patients the opportunity to communicate with our nursing staff via email. The utilization of email communication will allow your questions to be answered in the most efficient and accurate manner possible. All medical questions transmitted through email will be discussed with your individual practitioner so that your distinct and specific needs are addressed when responding to your inquiries.

Due to the volume of emails received, please allow 72 hours for a return email from our nursing staff. Our staff will make every effort to read and respond promptly to emails received.

Please do NOT use email for medical emergencies or other time sensitive matters, as these matters require more immediate attention. Emergencies can be classified as: severe abdominal pain, severe and persistent headache, shortness of breath, excessive bleeding, chest pain and signs of infection – if you are experiencing these symptoms, please contact your PCP or local emergency department. Under each of these circumstances, patients should seek direct medical care.

Nor should email be used when back and forth correspondence becomes prolonged. Emails are not to be used in place of a follow up appointment or phone consultation.

In regards to prescription refills, please do not make your requests using our email system. Rather, call the pharmacy where you originally filled your script so your pharmacy can send a refill request form for our providers, who will then determine if continuation of your medication is indicated. You may also follow our telephone prompts for prescription refills. Please allow 72 hours for all refill requests.

Please be as succinct as possible in your questions: please do not email more than 2 questions; please refrain from emailing complex questions or inquires that would require a significant change in treatment plan. A maximum of 2 emails per week, and not more than 100 words per email, will be addressed through our email system. *If your health concerns require more than 2 email correspondences in a given week, we ask that you call our office to schedule an appointment. A face-to-face appointment and physical evaluation for situations that require additional attention will ensure that you receive the highest quality of care at our Center.*

I have read and understand the information above, and agree to the terms of use for the Stram Center email system.

Patient Name:____

Signature:____

Date:___________________________________

Consent to Use E-mail to Exchange Personally Identifiable Information

Name: ____

E-mail Address: ____

D.O.B. ____________________

I understand that sometimes the nursing staff will communicate with me through email. I further understand that this form of communication of personally identifiable information concerning my treatment is without the use of encryption, and its associated risks.

Sending personally identifiable information by e-mail has a number of other risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the individual.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I, ________________________________, authorize the practice to communicate with me at my e-mail address, ________________________________, concerning my treatment. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

Patient Name:____

Signature:____

Date:______________________________

LABORATORY CONSENT FORM

I, ___________________________ (print name), am aware that prior to my appointment performed at the Stram Center, it is my responsibility to contact my insurance company in order to verify what my preferred laboratory is and my individual coverage for laboratory tests.

I am aware that the Stram Center is contracted with the following labs: Laboratory Corporation of America (LabCorp) and Quest Diagnostics, however this does not guarantee my individual coverage for testing.

I understand that it is my responsibility to provide the Stram Center with my most current insurance information and to notify the Stram Center immediately if there are any changes to my insurance.

I understand that if I receive a bill for my laboratory service it is my responsibility to contact my preferred lab directly, not the Stram Center. The Stram Center does not hold responsibility for lab charges after samples have left the office.

My insurance provider is: __________________________

My insurance ID is: ___________________________

My preferred lab is: ___________________________

I attest that all of the information above is true and correct to my knowledge.

Signed: ______________________________

Date: _________________

Ronald L. Stram, MD, Founder, Medical Director
90 Adams Place, Delmar, NY 12054 • t.518.689.2244 • f.518.689.2081 • www.stramcenter.com

Informed Consent/Waiver – Exercise Equipment

I ____________________________ acknowledge that by signing this document, I have voluntarily chosen to participate in a program of physical exercise, which may include an evaluation, that can enhance the musculoskeletal and cardiorespiratory systems in conjunction with my treatment at the Stram Center. In signing this document, I acknowledge being informed of the possible strenuous nature of the program and the potential for unusual, but possible physiological results including, but not limited to, abnormal blood pressure, fainting, heart attack or death.

I am aware that consultation with my primary care physician is recommended prior to initiating any exercise program. By signing this document, I assume all risk for my health and well-being and hold harmless of any responsibility, the instructor, facility or any persons involved with this program and testing procedures. I assume this risk and agree that my use of the exercise equipment shall, at all times, be at my own risk. I, on behalf of myself, my heirs and personal representatives, hereby knowingly and voluntarily agree to waive and release owner from any liability, loss, cost, damage, expense, claim or suit whatsoever for any and all injury, loss, illness, harm, cost, expense, claim, suit or damage resulting from or related to my use of the exercise equipment and facilities located therein. I understand that questions about exercise procedures and recommendations are encouraged.

I have received and read a copy of the current rules and regulations governing the use and hours of operation of the exercise equipment and facilities located therein, a copy of which is attached hereto, and I shall fully comply with all such rules and regulations, as they may be amended from time to time.

Patient Name:____

Signature:____

Date:_________________________________

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Patient Compliance and Guidelines for Contacting the Office

In order to best serve all our patients, please read and retain a copy of these guidelines for contacting our office for the following matters. The care a patient receives depends partially on the patient. Patients have a responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her. The Stram Center advises patients to attend their consultation with an advocate in order to ensure understanding of their treatment plan.

Questions for your Practitioner:

- I acknowledge the Stram Center medical staff is seeing scheduled patients during the day, and there is not always ample time to take my call directly regarding routine questions. Therefore, I will leave a detailed message on the medical voicemail line by following the proper telephone prompts listening for the name of my practitioner and individual nurse's voicemail extension.
- I agree and understand that I am to allow up to 72 business hours for a return call. I further acknowledge that medical questions left by voicemail are reviewed with individual practitioners and their nurses and will be prioritized by level of urgency.
- I agree that if it is an emergency I will not leave a voice message; if I am unable to speak with a member of the Stram Center directly I will call my local emergency facility or urgent care center for emergencies.
- Stram Center office hours for incoming calls are 8:30am-4:30pm Monday through Thursday and until 4:00pm on Friday's.

Prescription Refill Requests: Please do not wait until the last minute to request refills on prescriptions. I acknowledge the following:

- The Stram Center requires a minimum of 72 hours to refill prescriptions and cannot guarantee refills will be granted in less time.
- Refill requests should be left with my nurse by following the telephone prompts.
- Prescription refills will be considered by the medical staff for active patients only. For most prescription refills, my last appointment must not be more than 6 months prior to my request.
- Patients who have not been seen for a year or more must make a follow up appointment in order to receive new or refilled prescriptions.

Letters/Forms: Disability forms, social security forms, etc. are very complex and require time. There will be a fee for completing such forms. Please try to request letters relating to work and/or school from your provider at the time of your visit, when possible, and allow up to 2 weeks for turnaround. For release of medical records, please allow 10-14 days from the time your written request is received by our office for your request to be processed and completed. This request must be signed by you, authorizing us to release medical information. Please note, we only send medical information originating from our office, ie: your practitioner's medical office notes and/or labs ordered by him/her. Also, disability forms and other such applications will be considered for active patients only (within 3months) with adequate clinical history in our office. Thank you for your understanding and cooperation. Please contact Monique Vellano, our Practice Manager, at 518-689-2244 with any questions or concerns.

Name: ____________________________ Signature: _____________________________Date:___________