

**elainemd, inc**  
East-West Integrative Medicine  
3527 Ocean View Blvd  
Glendale CA 91208  
818.923.1076

**Non-Covered Benefits Fee**

At East-West Integrative Medicine, Dr. Elaine Chu's mission is to provide high quality, personalized health care to her patients with the emphasis on health, wellness and prevention. Dr. Chu has instituted features to improve accessibility and communication:

- We limit the number of patients in the practice so that there are not a lot of people trying to get an appointment at the same time. This allows patients improved access and generally seen for an appointment during office hours the same day or the next open office day.
- Online appointment scheduling.
- Dr. Chu will strive to be available 24 hours per day, 7 days a week. Coverage by another physician or practice group will be arranged when Dr. Chu is unavailable due to illness, travel, jury duty, holiday or vacation. Patients are able to contact Dr. Chu directly by cellphone or e-mail (secured or unsecured).
- Extended time for physician visits

This high level of personalized service, convenience, advanced access via technology, office amenities, and other services performed outside of office visits are NOT covered or reimbursed by the insurance companies.

Therefore, we need to charge a Non-covered Benefits Fee for all patients. Exemptions to this Fee are those patients who are younger than 26 years old, older than 65 years old and those for whom we only provide acupuncture services (i.e. they have another primary care physician).

**This fee will not be reimbursed by your health plan, although you may be able to use funds from a Medical Flexible Spending Account or Health Savings Account to pay for it.** Please consult your human resources department and or accountant if you qualify for reimbursement.

I, \_\_\_\_\_ (patient's name) elect the following fee schedule to be paid with my credit card on file with Dr. Elaine Chu:

**Please check box that applies to you:**

**Individual:**

<input type="checkbox"/>	\$25 per month, due first of every month
<input type="checkbox"/>	\$75 quarterly

**Family:**

	\$40 per month, due first of every month
	\$120 quarterly

- 1. I certify that I have read the above conditions of payment and agree to their terms.*
- 2. I understand that the Non-Covered Benefits Fee pays for the availability of the services that are not covered by my health insurance plan.*
- 3. I understand that I or my dependents are free to see a different doctor for medical care who does not charge this Non-Covered Benefits Fee.*
- 4. I understand that this Non-Covered Benefits Fee may be changed at any time with at least 3 months of advance notice.*
- 5. I understand that this agreement may be terminated by either party at any time, at-will, with or without cause with or without the giving or any reason by written notice to either party. Such termination shall become effective immediately upon receipt of such notice unless another date is specified by such notice. Upon termination of this agreement, the Non-Covered Benefit Fee will be refunded on a prorated basis as of the effective date of the termination.*

Print Patient's first name and last name \_\_\_\_\_ Birth Date \_\_\_\_\_

List family member(s) and Birth Date(s) \_\_\_\_\_

Signature of Financially Responsible Party \_\_\_\_\_

Please print first and last name and relationship of Financially Responsible party (if different than patient above) \_\_\_\_\_

Date \_\_\_\_\_