Patient Agreement for Medical Service with

Therapeuo Mastrogianakis LLC

I, _____, understand that Therapeuo Mastrogianakis LLC is a medical practice that focuses on finding the underlying cause of my symptoms, also known as Functional Medicine. Therapeuo Mastrogianakis LLC implements testing that is not standard of care based on American Medical Standards. Therapeuo Mastrogianakis LLC employs the use of specialty labs as well as LabCorp and Quest Labs, some of which may be covered by an insurance provider. I have the sole responsibility for the cost incurred with use of all specialty labs and any labs ordered through any specialty lab. Dr. Gena Marie Mastrogianakis, MD will guide me to the best of her knowledge about pricing and reimbursement, but ultimately, I assume responsibility for the payment of all labs ordered.

In Functional Medicine practices, which focuses on finding root causes, I understand that arriving at a formal diagnosis and implementing treatment plans will take more than 1 appointment. In most circumstances many appointments over several months are needed. I understand that Dr. Gena Marie Mastrogianakis, MD will guide me fully and provide me, to the best of her knowledge, a plan for how frequently I will need to be seen, and approximately how long it will take for my symptoms to decrease or resolve. Furthermore, if Dr. Gena Marie Mastrogianakis, MD is unable to help me using the absolute best of her knowledge and expertise, she will inform me of this as soon as it becomes apparent. I also understand that Dr. Gena Marie Mastrogianakis, MD will employ the best of her knowledge and understanding of medicine during all my appointments and do her best to help me with my medical complaints.

I understand that Dr. Gena Marie Mastrogianakis, MD does not serve as my Primary Care Physician. It is still necessary to have a Primary Care Physician for routine wellness exams, immunizations, and standard screening tests. I understand these services are not provided in office or ordered by Dr. Gena Marie Mastrogianakis, MD. I also understand that I may seek medical advice for any medical condition I have (including new/recent symptoms) with Dr. Gena Marie Mastrogianakis, MD. She will provide guidance on natural therapy options for my complaint and/or referred to my Primary Care Doctor or Specialist if necessary.

I also understand that a therapeutic Patient / Physician relationship is bidirectional. If at any time the patient or the physician deems the relationship is unbeneficial, the relationship may be terminated and transitioned to another provider at the request of the patient. Dr. Gena Marie Mastrogianakis, MD will provide referrals, if requested, for other Functional Medicine physicians or Primary Care Physicians in the area.

I have read all the above and agree to the terms described above

Patient Name: Full Printed _____

Guardian Name if applicable: Full Printed _____

Signature of Patient or Guardian if patient is a minor _____

Date _____

www.genamastromd.com
drmastrogianakis@gmail.com

Informed Consent:

I, _____, agree to receive a medical examination and treatment from Therapeuo Mastrogianakis LLC and its doctor, Dr. Gena Marie Mastrogianakis, MD. This includes, but is not limited to, giving my entire medical history, providing labs from other providers, allowing a complete physical examination, allowing collection of blood, stool or saliva and accepting recommendations and treatment plans to allow proper medical diagnoses to be made and healing to occur. I understand that Dr. Gena Mastrogianakis, MD is a Board-Certified Family Medicine doctor, in good standing with the Georgia Composite Medical Board, with an active State of Georgia Medical Doctor license.

I understand that the lifestyle interventions, supplement recommendations, medication recommendations and treatment modalities recommended to me by Dr. Gena Marie Mastrogianakis, MD are just that, recommendations. I assume responsibility to either implement or refuse treatment recommendations. This term is formally called "Shared Decision Making". At the time of my appointment, treatment recommendations will be explained to me, and possible side effects will be discussed. I fully understand it is impossible for Dr. Gena Marie Mastrogianakis, MD to know and foresee all side effects and reactions that could happen from recommended therapies. It is my responsibility to look at the medications, supplements and therapies and understand all their ingredients and why it is recommended I take them. If I do not understand, then it is my responsibility to discuss this with Dr. Gena Marie Mastrogianakis, MD.

I have read all the above and agree to the terms described above

Patient Name: Full Printed _____

Guardian Name if applicable: Full Printed _____

Signature of Patient or Guardian if patient is a minor _____

Date _____

www.genamastromd.com
drmastrogianakis@gmail.com

Patient Responsibility and Understanding

I, _____, understand that I am required to be an active participant in my health care. I am responsible for evaluating all supplements, prescriptions and therapies that are recommended and I am ultimately responsible to decide if they are appropriate therapies for me. During my appointment time my medical diagnoses and treatment protocols will be explained to me and I will have time to have all my questions answered. I understand that this occurs during my scheduled appointment time and I will be billed according to time.

I understand that all communication should take place via the patient portal on the appropriate electronic medical system. I will be sent an invitation to sign up for the patient portal at the time I schedule my first appointment with Dr. Gena Marie Mastrogianakis, MD. This is the most secure and appropriate form of communication regarding my healthcare.

The patient portal is for basic questions, any follow up questions after a visit, any side effects or medication refill requests. I understand that there is an acceptable 24 hour turn around time for my messages to be addressed. I also understand that in case of any emergency, the patient portal is **not** an acceptable way to receive medical care. If I have an emergency I will call 911 and present to the Emergency room. I will inform Dr. Gena Marie Mastrogianakis, MD through the patient portal that I have been in the ER and I will be given follow up instructions for when I should be evaluated by her after my hospital visit.

I also understand that complex questions that involve medical decision making or changes to treatment regimens, or interpretation of new / old labs must be done via an appointment with an associated appropriate fee based on time. This is very important to understand, and if there is any confusion on what needs an appointment, I agree to send a message through the patient portal, and let Dr. Gena Marie Mastrogianakis, MD decide if an appointment is needed.

I have read all the above and agree to the terms described above

Patient Name: Full Printed _____

Guardian Name if applicable: Full Printed _____

Signature of Patient or Guardian if patient is a minor _____

Date _____

www.genamastromd.com
drmastrogianakis@gmail.com

Payment

I, _____, agree to remit payment via Cash or Credit Card to Therapeuo Mastrogianakis LLC at the time my service (in person appointment or telemedicine appointment) is conducted. I understand and am fully aware Therapeuo Mastrogianakis LLC does not contract with any insurance company (including Medicare) and will not bill my insurance company for their service. Therapeuo Mastrogianakis LLC is a fee for service business. I will be billed according to the amount of time I spend with Dr. Gena Marie Mastrogianakis, MD either in person or over telecommunication.

Checks are not an acceptable form of payment. HSA and FSA Credit Cards are accepted by Therapeuo Mastrogianakis; however, payment is at the discretion of the Insurance provider. I do not hold Therapeuo Mastrogianakis LLC or their physician, Dr. Gena Marie Mastrogianakis, MD, responsible if my HSA or FSA Credit Card is declined or if they fail to cover the service rendered. If that occurs, I agree to remit payment in full using another acceptable form of payment to Therapeuo Mastrogianakis immediately. I am fully aware that refunds of any kind are not available.

No show appointments or same day cancellations (within 48 hours preceding the appointment) will be charged a $75 fee. Rescheduling will not be allowed until this fee is paid. *I agree to provide a credit card number with expiration date and CCV code for Therapeuo Mastrogianakis LLC to keep in my electronic health record, where it is secure*. This card will **only** be charged the above fee if applicable (no show/same day cancellation). There will be no charge prior to appointments if the appointment is kept. At the end of each appointment I will have an opportunity to submit payment with the same credit card on file or a different one. I will bring my form of payment (credit card or cash) to my in-person appointment. If I have a telemedicine appointment, I understand that I will be sent an invoice that is to be paid the same day, after the appointment is complete.

If I am scheduled for a hormone pellet procedure, I agree to be charged $75 for females and $175 for males, at the scheduling of the appointment so my supplies can be ordered. This fee is credited towards the amount of my pellet procedure. If I do not show for a pellet procedure, and I decide not to go forward with the procedure, I understand and accept that this fee is not reimbursed or applied to a future invoice of any kind.

I have read all the above and agree to the terms described above

Patient Name: Full Printed _____

Guardian Name if applicable: Full Printed _____

Signature of Patient or Guardian if patient is a minor _____

Date _____

Credit Card Information: Name on Card _____

CC Number _____

Expiration Date _____ CCV (code on back) _____

www.genamastromd.com
drmastrogianakis@gmail.com

Patient Privacy – Authorized Disclosure – HIPAA (health insurance portability and accountability act)

HIPAA is a term that describes how your Protected Health Information is used. By signing below, I declare I have read the HIPAA Notice of Privacy Practices, which has been provided to me from the American Academy of Family Physician prior to my first appointment with Dr. Mastrogianakis. I understand a copy of this document will be given to me if requested.

Patient Name: Full Printed _____

Guardian Name if applicable: Full Printed _____

Signature of Patient or Guardian if patient is a minor _____

Date _____

www.genamastromd.com
drmastrogianakis@gmail.com