



Please take your time to review the information below.

1. If you have a medical emergency, then please call 911 or go immediately to your nearest emergency room.
2. Once you have scheduled and confirmed your appointment, please utilize our HIPAA-compliant electronic secure messaging portal for all subsequent communication so that your personal health information would be protected from being compromised.
3. We currently do not accept any form of health insurance or Medicare or Medicaid, so we are considered an out-of-network or non-participating provider. We will provide you with a superbill after every appointment so that you can submit it to your insurance company. However, please note that it is your responsibility to determine what, if any, out-of-network benefits you have with your insurance plan.
4. You and/or your insurance company must pay the clinical laboratory directly for any lab test that you receive. We do not have any financial ownership interest in or compensation relationship with any of the labs that we use for testing. You should contact your insurance company to determine whether the lab has contracted with your insurance company.
5. We will spend new-patient visits with you primarily obtaining your medical history, reviewing your medical records, discussing health goals, and deciding what lab tests are indicated. We will order the lab tests at that visit and we will review the test results at the follow-up appointment when we will discuss our clinical recommendations in full detail.
6. Payment for services rendered is expected at the time of service  
New patient 75-minute appointment \$400  
Follow-up 45-minute appointment \$200  
New or follow-up 15-minute medical marijuana appointment \$150  
Brief 15-minute check-in appointment (established patients only) \$50
7. Our HIPAA privacy information is available at [www.renewdirection.com](http://www.renewdirection.com).
8. We do not provide emergency or after-hour care. You must maintain a primary care physician while you are a patient of ours.
9. Please provide us as much notice as possible for medication refill requests and no less than 2 weeks prior notice.
10. We provide a blend of allopathic and homeopathic care. Although we do provide conventional medical care and prescribe conventional medications, we attempt to initially and primarily offer integrated and functional care, such as vitamins, herbs, meditation, nutritional supplements, and other homeopathic remedies. The care that we provide is neither a sole treatment for your condition nor a replacement for all of your medications. We do not prescribe narcotics, Adderall, Ambien, or benzodiazepines.



ALLISON FOX M.D.

# RENEW

INTEGRATIVE AND FUNCTIONAL MEDICINE



11. The purpose of functional medicine laboratory testing is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests are not intended to diagnose disease. We utilize conventional lab tests as well as functional medicine assessment. Functional medicine evaluates the body as a whole with a special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

12. We offer a 15% discount on nutritional supplements available through Wellevote. We recommend products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering various factors, including the quality of science behind the product, the quality of the ingredients themselves, the quality of the manufacturing process, and the synergism among product components. However, we are not offering any warranty of any type or making any representation about the quality or efficacy of these products or claiming that they are better than those sold in retail stores and pharmacies.

13. Please provide us at least 72 hours advance notice if you need to cancel your appointment.

I have read and understand the above.

Patient's Signature: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Signature of Patient's Parent/Legal Guardian: \_\_\_\_\_

Name of Patient's Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_