Laurie A. Marti, MD, PLLC
PO Box 2307
Kirkland, WA 98083-2307
Phone: 425-232-1965
Fax: 425-463-4267
Email: lmartimd@lauriemartimd.com
www.lauriemartimd.com

NAME: _____ **DATE:** _____

CONSENT FOR TREATMENT AND GENERAL OFFICE POLICIES

I request evaluation by Dr. Laurie A. Marti, M.D., PLLC. I understand that Dr. Marti offers specialized services that may require advanced diagnostic testing and that Dr. Marti is not functioning as my primary care physician. I understand that I must have a primary care physician for standard medical and preventative care and I do not/will not rely on Dr. Marti for that role. I agree to see my primary care physician (and/or gynecologist) for regular monitoring and preventative measures (complete physicals, rectal exams and/or colonoscopy, EKGs, mammograms, pelvic/breast exams, PAP smears, and prostate exams, etc) on a regular basis as appropriate for maintenance of care. I understand that there are general guidelines for these preventative measures and agree to discuss the potential need for these screening measures on a regular basis with my primary care physician. I understand it is not the responsibility of Dr. Marti to arrange for these preventative measures, but agree to comply if Dr. Marti suggests that my primary care physician perform such measures.

Dr. Laurie A. Marti may recommend a number of innovative natural and pharmaceutical treatments that may not fall under the strict guidelines of conventional medicine as defined by those health care methods of diagnosis, treatment, or interventions that are offered by most licensed physicians as generally accepted methods of routine practice, based upon medical training, experience, and review of the peer reviewed scientific medical literature and that some of the recommendations may be considered complementary, integrative, alternative, non-conventional or non-standard. You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so that you make an informed decision whether or not to undergo the procedures after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply to make you better informed so you may give or withhold your consent to the procedure or treatment.

I voluntarily request that Dr. Laurie A. Marti, as my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to evaluate my condition, which may include but not limited to chronic fatigue immune deficiency syndrome, fibromyalgia, fatigue of unknown etiology, menopause, menstrual irregularities, muscle pain, immune deficiency, preventative medicine, hormonal deficiencies, chronic infections, pituitary dysfunction, suboptimal hormone levels, coagulation defects, excess burden of heavy metals, neurotoxins, sleep disorders, hormonal resistance syndromes, mitochondrial dysfunction, genetic testing, migraines, depression, anxiety, insulin resistance, and digestive problems.

I understand it is not always possible to give a definitive diagnosis and any diagnosis may not be agreed upon by other physicians and may lie outside of standard conventional criteria to make such a diagnosis.

I agree to comply with requests for ongoing testing to assure proper monitoring of my therapy. I understand that there are no refunds for prepaid out-of-network testing. I have not been promised or guaranteed any specific benefit from the services at the office of Dr. Laurie A. Marti, MD, PLLC.

I agree to the following office charges for scheduled in-person and telemedicine consultations: 30 minutes ($275), 45 minutes ($400), 60 minutes ($450), 90 minutes ($675), and 120 minutes ($800). I agree to pay for all forms and letters at the minimum charge of $75 per page. Long forms and letter writing that require >10 minutes, will be charged at the rate of $500/hour. I understand that Dr. Laurie Marti MD is not contracted with any insurance companies, Medicare, or Medicaid. I agree that I will not bill Medicare or Medicaid for any fees paid to Dr. Laurie Marti, MD. Payment must be made at time of service with a credit card for telemedicine consultations unless other arrangements are made.

I agree to the office communication policy as follows: email communication is for brief, non-emergency communication ONLY. It is not intended as a substitute for office visits, and complex or excessive email communication is discouraged and will be charged at the rate of $500/hour if >10 minutes of cumulative time is required. Return emails may be delayed but usually answered within 3 business days. Please call Dr. Marti for any emergent communication or if an answer if needed urgently. Phone calls are usually answered within 24 hours, and sooner for emergent issues. Non-appointment phone calls will be charged at the rate of $500/hour. Unless otherwise agreed upon, text messaging is not appropriate as a means of communication.

Please allow 48 hours for medication/prescription refills and pharmacies should be contacted first for refills so that they can fax the refill request to Dr. Marti.

I have been informed that many insurance companies may not pay for some services, and therefore agree to be responsible for all laboratory, pharmacy, therapies, nutraceuticals, and office visit charges, with the full understanding that I may not be reimbursed by my insurance company. Dr. Laurie A. Marti, MD, PLLC, cannot be responsible for an insurance company's denial of payment. Some insurance plans may not pay for certain medications without a special authorization or may require additional information for coverage of labs/medications. I agree to reimburse Dr. Marti for her time in speaking/filling out forms with insurance companies to obtain authorization for medication or laboratory testing coverage at the rate of $500/hour. I understand that I will be charged $100.00, if I do not show up for an appointment or do not give at least 24-hour advance notice of a cancellation.

Please initial and sign below stating that you agree to be charged for the amounts listed above and office policies.

_____(Initial Here)

_____ _____

Patient Signature Date