

BHRT & Integrative Wellness, LLC
Christine Kallander MSN, ANP

Welcome to my practice!

I would like to take this opportunity to welcome you and thank you for choosing my practice to participate in your healthcare. I look forward to providing you with a personalized, comprehensive focus on wellness and prevention. As continuity and coordination of care is essential in meeting your healthcare needs, I will work closely with you in a “team approach.” To accomplish this please consider the following:

- Please have all forms completed prior to your visit. If your paperwork is not complete at the time of your visit, you will be charged for the extra time required to complete your appointment.
- Document all medications, vitamins and supplements.
- Cancellations or changes to appointments require at 24-hour notice.

We wish to provide a chemical and fragrance-free environmental. Please refrain from wearing perfume, aftershave, scented hand lotions scented hair products, and strongly scented essential oils and/or similar products when visiting our office.

Thank you again and I look forward to seeing you,

Chris Kallander MSN, ANP
Advanced Nurse Practitioner

Initial: _____
Date: _____

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How my practice works:

1. We are partners in making all treatment decisions to balance and enhance your health.
2. **You are fully responsible for all charges to your account at BHRT & Integrative Wellness, and payment is due at the time of service.**
For your convenience, we accept Visa, Mastercard, American Express and Discover card.

Be Advised: Insurance companies may not pay for certain services suggested by BHRT & Integrative Wellness. Please feel free to call for assistance.
3. **I voluntarily and knowingly assume all risks associated with my functional therapy and will confirm all my questions have been answered prior to departing a Telemedicine or in-office appointment. I understand that I always have the option of discontinuing therapy with NP Kallander at any time, and undergoing treatment with another provider. I acknowledge NP Kallander has done nothing to dissuade me from choosing another form of therapy.**
4. Fees for medical services are based on current fees around Alaska, our costs, supplies, time, administrative costs and much more. Please understand there may be additional fees for copying and mailing of medical records.
5. If you miss a scheduled appointment due to extenuating circumstances, an oversight, or cancel with less than 24 hours' a "no-show fee" of \$325 may be assessed after one grace period. You will be required to pay this fee before scheduling additional appointments. You are expected to keep your appointments and I endeavor to stay on time. There may be an occasional urgent issue that may cause a delay.
6. **You will need a yearly in-office evaluation with a brief physical exam, once yearly hormone testing to obtain hormone refills, and once yearly female/male exam as recommended by your primary care provider.**
7. Evidenced based management of bio-identical hormone management takes time and may require a number of appointments to achieve balance. BHRT & Integrative Wellness, LLC strives to use the lowest doses and safest preparations available. These may include prescription medications, supplements, bio-identical hormones, and nutrition. Prescription medications are not used unless required for a specific medical condition.
8. Compounded hormones may not be covered by insurance.

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9. Questions and concerns that require a medical diagnosis will be need to be addressed during appointments, NOT by email.
10. Prescriptions are only refilled on days the office is open. Please plan ahead and allow 5 days for prescription refills.
11. You will be notified when lab results arrive and are expected to schedule a follow up appointment to review. If you have questions, please feel free to call.
12. BHRT & Integrative Wellness, LLC does not participate in Medicare, Medicaid, Worker's compensation, or insurance billing.
13. In the event of an emergency please call 911 or proceed immediately to the emergency department. If you need assistance when I am teaching or attending classes, please consult your primary care provider, urgent care or emergency care.

******To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited at any location within these offices. Thank you for your understanding and compliance. ******

I have read, understand and consent to the above and I have had the opportunity to ask questions:

Patient's Name (Print)

Patient's Signature

Date

Signature of Witness

Date

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Date: _____

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