TENPENNY
Integrative Medical Center
www.TenpennyIMC.com
440-239-3438

Welcome!

Thank you for choosing Tenpenny Integrative Medical Center and ECP therapy as part of your journey to optimal health.

Financial Information:

• Payment in full is due at the time of service. We accept cash, check, and most major credit cards.

• While we do not participate with any insurance companies, we do participate with Care Credit financing.

• Under our office policies, you may not submit any receipts or HCFA forms to insurance for reimbursement purposes, including Medicaid and Medicare.

PLEASE ARRIVE AT LEAST 15 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME WITH YOUR NEW PATIENT PAPERWORK FILLED OUT.

If you do not arrive on time for your scheduled appointment, TIMC reserves the right to reschedule your appointment to another date and time.

About ECP (External Counterpulsation):

External Counterpulsation (ECP) is administered using a technology that inflates (with air) and deflates three pairs of cuffs (similar to large blood pressure cuffs). The cuffs are wrapped around the legs and buttocks and are timed with your heartbeat. The cuffs inflate when the heart is resting and deflate when the heart is pumping. The special pumping cycle sends blood back to your heart at the time when it normally gets its blood, increasing the supply and decreasing the amount of work the heart must do to send blood through the body.

Consent:

I hereby give consent to Tenpenny Integrative Medical Center to perform ECP Therapy.
I understand and acknowledge that no warranties, assurances, or guarantees of a successful therapeutic outcome have been made to me. I desire to undergo ECP after having

considered the information in this document. Information has been given to me from this document and other educational materials provided by TIMC and its staff.

To the fullest extent permitted by applicable law, signees and participants will hold harmless and indemnify TIMC against any and all claims and actions arising out of participation in ECP therapy and the participants waive any/all rights, claims, and causes of action against TIMC and its staff, administration and executives from claims, suits, or actions of liability or damages, that may occur from my participation in this activity and from any further or future health-related issues I may experience. I voluntarily accept all risk associated with ECP therapy, and I enter this agreement to receive therapy of my own free will and at my request. TIMC has no responsibility nor burden of liability in the event of loss or harm.

We uphold a no refund policy on all our packages. Once purchased, the commitment to the service is final.

Please note that by scheduling an appointment with us, you agree to the terms outlined in our Cancellation and Refund Policy. We appreciate your understanding and cooperation in these matters. If you have any questions or need further clarification, do not hesitate to contact our center during business hours. Thank you for choosing our services, and we look forward to serving you.

Client Signature: _____ Date: _____

If signed by someone other than the client, please indicate the relationship: _____

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Please read the following information carefully before signing. It is important that you understand the safety guidelines, contraindications, and precautions related to ECP (External Counterpulsation) Therapy. Your signature indicates that you acknowledge these conditions and agree to notify our staff of any changes to your health during your course of treatment.

ECP (External Counterpulsation) Therapy – Contraindications & Precautions

Safety Information:

- ECP is non-invasive and painless.

- No special preparation is needed before treatment, and there is no required recovery time afterward.

- ECP may be used after stent placement, bypass surgery, or with a pacemaker.

- For those who have recently undergone surgery, a minimum of 6 weeks post-operative recovery and a written clearance from your physician are required.

Absolute Contraindications:

- Active blood clots: Deep vein thrombosis (DVT), pulmonary embolism (PE)

- Active thrombophlebitis: Red, swollen legs with superficial blood clots

- Aortic aneurysm: Diameter greater than 3.5 cm

- Uncontrolled arrhythmias: Especially atrial fibrillation interfering with EKG signal

- Bleeding diathesis: Medical conditions causing abnormal bleeding or bruising

- Current use of Coumadin (warfarin)

- Pregnant or possibly pregnant

- Severe peripheral vascular disease: Poor leg circulation with skin ulcers

- Valvular heart disease: Moderate to severe aortic insufficiency

- Active cancer

Additional Precautions – Require Medical Review:

- Advanced congestive heart failure (CHF): Must tolerate lying flat during treatment

- Heart rate irregularities: Greater than 120 bpm or less than 40 bpm

- Other valvular disorders: Severe mitral or aortic stenosis

- Uncontrolled hypertension: BP > 180/120

- Recent back or spinal surgery

- Recent cancer surgery: Minimum 6 weeks post-op with healed incision and physician clearance

ECP may lower blood pressure, improve the ability of the heart to pump, and lower the risk of sudden cardiac death. During my ECP sessions, I give the staff permission to monitor my blood pressure and perform non-invasive cardiac testing.

Initial: _____

Acknowledgment:

I understand that active contraindications prevent me from starting or continuing ECP therapy. It is my responsibility to inform the staff if there is any change in my health status throughout the course of treatment.

Client Signature: _____ Date: _____

If signed by someone other than the client, please indicate relationship: _____

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INTEGRATIVE MEDICAL CENTER

AUTHORIZATION & ACKNOWLEDGEMENTS

☐ INITIAL ☐ ANNUAL UPDATE

TREATMENT AUTHORIZATION: I (print name) _____ authorize medical treatment of myself or my minor child by physicians, nurse practitioners, physician assistants, nurses, chiropractors, acupuncturists and medical assistants and staff by Tenpenny Integrative Medical Center.

NOTICE AS TO NATURE OF SERVICES: I understand that the care I receive at Tenpenny Integrative Medical Center may be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine, or innovative services. Many of these services may not be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my physician may request laboratory testing which may include venipuncture, analysis of stool, urine, saliva and breath.

NOTICE THAT SERVICES ARE NOT PRIMARY CARE: I understand that no physician or any other practitioner I see at Tenpenny Integrative Medical Center is acting as my primary care physician unless otherwise agreed to by a physician in writing. As such, emergency services are not offered. I understand that even though my physician(s) and Tenpenny Integrative Medical Center practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a hospital based pediatrician if I am seeking treatment for my children. I also understand that it is my responsibility to inform Tenpenny Integrative Medical Center who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed at Tenpenny Integrative Medical Center in order to properly and safely coordinate my care. My primary care physician is:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

I am also being treated for _____ by:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL TENPENNY INTEGRATIVE MEDICAL CENTER SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit, unless other specific arrangements have been made. I am responsible for charges incurred for all treatment rendered, unless otherwise agreed to in writing. I further understand Tenpenny Integrative Medical Center will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Tenpenny Integrative Medical Center to take action to secure payment of an outstanding balance owed.

Patient Name: _____ **Date:** _____

NOTICE TO MEDICARE PATIENTS: The physcians at Tenpenny Integrative Medical Center have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at Tenpenny Integrative Medical Center**.** I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said services(s).

CLAIM MANAGEMENT: My treating practitioner(s) may respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I may be charged for responding to requests for information. Insurance claim forms and information will be provided to patients at the time of visit or sent to you upon the availability of the appropriate documentation. Tenpenny Integrative Medical Center does not typically send information directly to insurance carriers due to problems we have experienced with carriers misplacing claims.

FURTHER NOTICES AS TO POLICIES REGARDING INSURANCE: Tenpenny Integrative Medical Center will provide claim forms for submission to insurance; submission shall be the patient's responsibility. Claim submissions may or may not be for covered services and may or may not include procedural codes or other data sufficient to support my insurer's determination as to what services it will reimburse. Tenpenny Integrative Medical Center may provide records requested by my insurance company. If possible, Tenpenny Integrative Medical Center will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions, Tenpenny Integrative Medical Center cannot be responsible for any information that turns out to be incorrect.

NO GUARANTEES: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at Tenpenny Integrative Medical Center.

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form, I acknowledge that I have received a copy of Tenpenny Integrative Medical Center Authorizations and Acknowledgements.

Patient's Signature:	Date:

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7380 ENGLE ROAD
MIDDLEBURG HEIGHTS, OHIO 44130
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CANCELLATION POLICY

When you schedule an appointment, we reserve time just for you. Upon scheduling your first appointment, we will process your credit card over the phone for $50.00 to hold your appointment time. The $50.00 will be applied towards your first appointment unless you fail to give proper notice to cancel or reschedule. TIMC reserves the right to keep the $50.00 as your cancellation fee for a no show or failure to follow our cancellation policy.

All scheduled appointments require a minimum of two-day notice, excluding Saturdays and Sundays. You must call the office to make schedule changes. Email and text are unacceptable. Patients who cancel without proper notice or fail to show for any scheduled appointment will be subject to a $50.00 charge. We appreciate your understanding and respect of our policy.

I, _____, hereby authorize Tenpenny Integrative Medical Center to charge my credit card for $50.00 in the event that I do not adhere to TIMC's cancellation policy, as outlined above. This authorization will remain in effect indefinitely; I reserve the right to cancel this authorization at any time. It is my responsibility to notify TIMC of any changes regarding this credit card authorization, including change of numbers, expiration dates, etc. My signature below confirms that I understand and agree to this authorization.

Credit Card Number: _____ Exp. Date: _____

CVV Code: _____ Billing Zip Code: _____

Name On Card: _____

I have read and agree to adhere to this policy.

Signature: _____ Date: _____

Last Name			DATE
First Name			DOB
Address			Age MALE FEMALE
City	**State**	**Zip**	
HOME TELEPHONE:	**WORK TELEPHONE:**	**MOBILE PHONE**	
Use this number as my primary contact	Use this number as my primary contact	Use this number as my primary contact	
OK to leave detailed message	OK to leave detailed message	OK to leave detailed message	
Leave your name and call back number only	Leave your name and call back number only	Leave your name and call back number only	
Email address:	**May be add your email to our in-office email database? YES NO**	**WE PROTECT YOUR EMAIL PRIVACY AND IS USE FOR IN-OFFICE ALERTS AND PROMOTIONS ONLY.**	
EMERGENCY CONTACT NAME	EMERGENCY CONTACT NUMBER	RELATIONSHIP:	

INSURANCE INFORMATION		
Insurance Company:		
Address:	City, State and zip	
Insurance ID number	Group Number	
Insurance Policy Holder	Policy holder date of birth:	
I give my permission to share my medical information with		
My relationship to this person is		
I attest to the best of my knowledge, the information above is true and accurate.		
Signature:	**Date:**	

How Did You Hear About Us?

Patient referral, who can we thank? _____

Physician Recommendation: [ ] Yes Physician Name: _____

Please select all that apply (check all that apply):

Social Media:

[ ] Instagram [ ] Facebook [ ] Twitter [ ] TikTok [ ] Telegram [ ] CloutHub [ ] GAB

[ ] GTTR [ ] Truth Social [ ] Rumble [ ] BitChute [ ] Internet Search [ ] Google Search

Email:

- [ ] DrTenpenny.com
- [ ] Tenpenny Integrative Medical Center (TenpennyIMC.com)
- [ ] ECP Studio in Ventura, CA (TenpennyECP.com)

Podcast / Interview:

- [ ] Happy Hour with Guest
- [ ] This Week with Dr. T
- [ ] Happy Hour Bible Study
- [ ] On Your Health with Dr. Tenpenny (Brighteon)
- [ ] Morning Coffee with Dr. T
- [ ] Deep Dive
- [ ] Critically Thinking

Advertisement: (Please indicate where you saw the ad)

_____

Church: (Church name)

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