Patient Responsibility Agreement

Thank you for choosing our practice for your health care needs. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our patients' code of conduct and financial responsibility is important to our professional relationship. Compliance with our practice policies impacts that relationship. If you have any questions about your responsibilities, our fees or policies please do not hesitate to ask.

PATIENT RESPONSIBILITIES

RESPECT FOR PROVIDERS, STAFF AND OFFICE

Many of the policies and procedures our office dictates are the result of mandates by local and federal requirements as well as insurance companies. Our staff have nothing but your best interest in mind when working with you and as such deserve mutual respect when you visit our locations. Any instance of intimidation, bullying or disrespect toward our staff may result in a patient being permanently discharged from our practice.

PRE-VISIT REGISTRATION

Our office utilizes a pre-visit registration or check-in process. This allows our patients to complete new patient information or verify existing patient data at their convenience prior to their visit. Participation in the pre-visit check-in process is required for all visits to our office. The pre-visit link for registration can be sent via email or text message and as such all patients will be required to maintain a valid email and/or cell number on file with our office.

ATTENDANCE OF SCHEDULED APPOINTMENTS

Our providers recommend return appointments based on your individual needs. Missing scheduled or recommended follow up care can delay further treatment, prescription refills and overall improvement in your conditions. Patients are asked to comply with all scheduled appointments while a member of our practice. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, failure to notify our office of a missed appointment prevents others from accessing care as well. At the discretion of the practice, if an appointment is not cancelled at least 24 hours in advance, you will be charged a fee; this will not be covered by your insurance company.

PERSONAL DEMOGRAPHIC INFORMATION

Maintaining current demographic information including contact phone numbers, email and address are vital in completing your post-visit care. Patients are responsible for ensuring all demographic information is current and correct at each visit. Participation in our electronic patient portal is required and as such, all patient accounts must have a current email address on file. In the event that a patient does not have an email, a trusted family member or friend may be designated to receive the portal invitation email and assist with patient portal enrollment.

PROOF OF INSURANCE

You will be asked to show the receptionist your current insurance card at each visit. Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

COMMUNICATION CONSENT

HIPAA Notice of Privacy Practice: I certify that a copy of the Notice of Privacy Practices has been made available to me. In order to comply with the Health Insurance Portability & Accountability Act of 1996, please complete the following communication consent.

EMERGENCY CONTACT: The practice will not release confidential information by home telephone, answering machine, work telephone, voice mail or cell phone unless authorized below. Designating an emergency contact is not considered authorization to disclose confidential information. Confidential information will not be left with an unauthorized person who may answer the telephone. Who may we contact in case of emergency?

Name: _____ Relationship: _____

Phone #: _____

AUTHORIZATION TO DISCLOSE PRIVATE HEALTH INFORMATION (PHI): I authorize the practice to contact me and/or authorized person(s) designated below and convey private and confidential health information. I assume the responsibility to notify the practice whenever this information changes. I am authorizing a **detailed message, including information that may be construed as PHI,** to be left with the individual listed below.

Please list name/relationship of other people authorized to receive information about your care:

Name: _____ Relationship: _____

Phone #: _____

GENERAL CONSENT FOR TREATMENT

I hereby authorize the healthcare providers of the practice and his/her staff, to perform and do hereby consent to such medical treatment as he/she feels is necessary, including diagnostic procedures, medical examinations, and treatment that may, in his/her opinion, be medically necessary. I consent to the testing for infectious diseases, including but not limited to, syphilis, HIV, hepatitis and testing for drugs if deemed advisable/recommended by my healthcare provider.

I understand that I have the right to opt-out of or decline any specific diagnostic procedures, medical examinations, treatment options, and testing, including HIV screening at any time. I understand that written certification is required to opt- out of HIV screening at the time testing is recommended.

I certify that I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantee has been made as to the result of any procedure, treatment, or examination.

I understand that my confidential health information will be disclosed for the purposes of treatment, payment, and/or practice operations, consistent with the HIPAA regulations set forth by the Office of Civil Rights (OCR).

AFFIRMATION:

This agreement will remain in effect until revoked in writing. A photocopy of this acknowledgement and assignment of benefits is considered to be the same as the original.

By signing below, I acknowledge that I have read, understand and agree to the information detailed in the Patient Responsibilities, Communication Consent, Authorization to Release PHI and General Consent for Treatment.

_____ _____

Patient Signature (or legal Guardian for minors) **Date**