Family Practice | Mental Health
Integrated Wellness

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We are pleased that you have chosen us as your healthcare provider. We require all patients to sign this **Authorization and Consent to Treatment form** before receiving medical services. This form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility concerning services received as outlined in this policy.

Please keep in mind that we are a small office. We do our best to return calls promptly as well as fully assist patients in every way we can. HEALING HANDS HAS A ZERO-TOLERANCE POLICY CONCERNING DISRESPECT OR HARASSMENT OF OUR STAFF AND PATIENTS. Therefore, any individual who engages in disrespectful and/or abusive behaviors towards staff or another patient (including foul/disrespectful language) MAY BE SUBJECT TO IMMEDIATE DISCHARGE from the practice.

By completing and signing this form, you acknowledge this policy and agree to refrain from disrespectful or abusive behaviors towards our staff and other patients.

Please initial and review each policy.

_____ **INSURANCE** – We ask all patients to provide their insurance cards, prescription cards, and proof of identification at **EVERY visit**. If you do not provide an up-to-date insurance card or we are a non-participating practice with your insurance, **you will be billed as self-pay**, and payment will be expected in full at each visit. We will not be able to bill or authorize medications without your current information. **It is your responsibility to know your insurance benefits**. Remember that our fees are for physician services only. You may receive additional bills from laboratory, radiology, or other diagnostic-related providers.

_____ **COPAYMENTS AND DEDUCTIBLES**- Patients and their legal representatives are ultimately responsible for all service charges. **All Copays and deductibles must be paid at the time of service**. This arrangement is part of your contact with your insurance company. It is your responsibility to know your insurance benefits. Please get in touch with your insurance company with any questions you may have about your coverage or insurance payment issues.

_____ **NON-COVERED SERVICES** – Please be aware that some of the services you receive may be noncovered or not considered necessary by Medicare or other insurers**. You must pay for these services in total during the visit**.

_____ **CLAIM SUBMISSIONS** - We will submit your claims and assist in any way we reasonably can to help get your claims paid. Your insurance company may require you to supply certain information directly. **It is your responsibility to comply with the insurance request**. Please be aware that the **balance of your claim is your responsibility whether or not your insurance company pays your claim**. If you have an annual wellness physical, gynecological, or other preventive exam but need or request additional services, we may bill you for those additional services. All services for minor patients will be billed to the custodial parent or legal guardian.

_____ **NO SURPRISE ACT/GOOD FAITH OF ESTIMATE OF CHARGES-** If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the NO SURPRISES ACT, healthcare providers must give patients who don't have insurance or are not using insurance an estimate of the bill for medical items and services. You can ask your healthcare provider and any other provider you choose for a Good Faith Estimate before you schedule an item or service. You can dispute the bill if you receive a bill of at least $400 more than your Good Faith Estimate. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

_____ **OUTSTANDING BALANCES** – **All outstanding balances are due on receipt of the statement**. If you come for another visit and have an outstanding balance, we will request payment for **both the new and your outstanding balance**. Your outstanding balance can be paid conveniently via our patient portal, mail, or office. If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient, and you may not be allowed to schedule any additional services **unless special arrangements have been made**.

_____ **REFERRALS/AUTHORIZATIONS** – **You are responsible for understanding the limitations of your insurance policy**, including:

- if a referral or authorization is required for office visits. If it is required and you do not have the appropriate referral or authorization, **you may be billed as an uninsured patient**.
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy
- Any co-payment, coinsurance, or deductible that may apply
- If your insurance requires prior authorization for medications, this can take up to 72 hours.

_____ **TELEHEALTH: VIRTUAL/PHONE APPOINTMENTS –** Any video or phone call appointments with your provider to discuss results, medication, or anything else involving your medical history and care will be charged to your insurance company (or self if you do not have insurance. This could result in a copay, co-insurance, or other charges as indicated in your insurance policy.

_____ **PRESCRIPTION REFILLS** – Please call for refills several days before running out of medication. The practice is allowed 48 business hours to refill medications.

_____ **COMMUNICATION WITH PROVIDERS** – Please call the office or send a patient message through the portal to communicate with your provider. If you are receiving primary care and mental health management services **Please do not email**. This prevents other staff members from being able to assist as we are unable to trace emails to your chart**. If you are receiving therapy services please ask your therapist the best means of contact with them, this may include email**.

_____ **FORM COMPLETION FEES** :

- FMLA $75.00
- DMV $50.00

If you have another form that needs to be filled out, please let us know, and we can give you a cost if there is any. **Some forms may require an appointment (telehealth fees apply for phone and video appointments)**

_____ **NO SHOWS-** If you miss your appointment or cancel within 24 hours of your appointment**, you may be charged the following fees**:

- New patient appointments $100
- Annual Physical Exams $100
- Well Women Exams $100
- Therapy Appointments $100
- Procedures $50
- Follow-up appointments $50

Missed appointments interfere with our ability to provide patients with the highest quality of care. Please help us serve you better by keeping your regularly scheduled appointments.

I certify that the insurance information I have provided is accurate, complete, and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and any of my insurance carriers to Healing Hands Integrated Wellness & Primary Care for services provided. If my health insurance plan does not pay Healing Hands directly, I agree to forward all health insurance payments I receive for the services rendered. I authorize Healing Hands to release the information needed to my health insurance plan to determine these benefits or the benefits payable for related services. I understand that if Healing Hands does not participate in my insurance plan's network or if I am a self-pay patient, this assignment of benefits may not apply.

Considering the services provided by Healing Hands, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by the law, I will reimburse Healing Hands for all costs, expenses, and attorney's fees incurred by Healing Hands to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I know that my failure to do so may result in a reduction or denial of benefit payments and that I will be responsible for all balances due.

I, with this, voluntarily consent to render such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a virtual or phone visit), I

hereby consent to participate in such telehealth visits and their recording, and I understand I may terminate such visits at any time. My consent shall also cover the carrying out of the orders of my treating provider by Healing Hands staff. I acknowledge that neither my provider nor their staff have made any guarantee or promise as to the results I will obtain.

I understand and agree that my provider may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, and any other communications from my provider. I understand I may opt out of receiving all such communications from my provider by notifying the staff of Healing Hands.

Printed name: _____

Signature: _____

Relationship to patient: _____

Date: _____