Patient Policies

Dear Patient,

Welcome to Clover Family Medicine! We are honored to be able to care for you. Welcome to our family. Our goal is to care for you as such. Please be courteous to us as well while we work to keep you in the best health possible. Below you will find our current policies.

Sincerely,

The Team at Clover Family Medicine

Appointments: Office hours are scheduled by appointment only. In scheduling appointments, it is our intent to see you as close to your scheduled appointment time as possible in respect of your time. Our staff and physicians will make every effort to accommodate urgent add on requests. Please be aware that due to the nature of our practice, emergencies can occur and may cause delays. Individuals that arrive prior to their appointment times may be seen early, only if the schedule allows. If you arrive over 15 minutes after your quoted appointment time, you may be asked to reschedule.

Cancellations/No Shows: If an appointment is missed or not changed 24 business hours prior to the appointment, there will be a charge of $40. We reserve your appointment exclusively for you. Please understand that last minute cancellations postpone other patients from being scheduled.

I understand the cancellation policies and fees.

Signature: X_____

Minors: Minors under the age of 18 will only be seen without a parent or guardian if written and verbal consent is provided.

ePrescription History Consent: Our office utilizes ePrescriptions to reduce medication errors and enhance patient safety. One optional feature of this service is the ability to obtain your list of medications from your pharmacy benefit manager using the SureScripts service.

I authorize Clover Family Medicine to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

Signature: X_____ Date:_____/_____/_____

Notice Regarding Payments/Insurance Claims: If we are filing insurance for your visit, we must have all of the necessary information. If we are unable to verify your insurance, we will not be able to file your insurance, and payment will be required at the time of service.

The exact amount that your insurance company will pay for your claims cannot be determined with complete accuracy until the claim has been filed to your insurance company and they have processed it. Your office co-pay is due at the time of service. If you have a health plan with coinsurance or unmet deductible, that will also be due at the time of service. In many cases, the co-pay will only cover the office visit and any procedures (such as biopsies, removing or freezing a lesion) performed in the office may fall to your office surgery deductible/coinsurance. If we can determine with reasonable certainty that your insurance company is likely to leave a balance that is due by you the patient, we will collect the estimated amount due at the time of service.

If you are paying as a self-pay patient, payment is due in full at the time of service. We do give an immediate payment discount for self-pay.

Please be aware that cosmetic procedures such as benign mole removal, skin tag removal, and cosmetic skin consultations will be your financial responsibility if your insurance plan determines these are not medically necessary. Botox and IV therapy will be a cash only service.

Our policy does require that you present your insurance card and a valid driver's license or photo ID at check in at every appointment.

Past-Due Balances: Any and all balances that are outstanding for over 60 days will automatically incur a $20 administration fee.

Clover Family Medicine works with collection agencies for any account that is delinquent over 90 days. If your account is turned over to a collection agency, an additional $30 fee will be administered for the costs associated with collections.

Returned Check Fee: A $35 processing fee will be assessed for checks that are returned for insufficient funds.

Assignment of Benefits: I hereby authorize payment of all health insurance benefits to Clover Family Medicine, and allow assignee to release all information necessary to secure payment. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Notice of Privacy Practices Acknowledgement Form

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Clover Family Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Clover Family Medicine's Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been

provided a copy of or access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that Clover Family Medicine reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be sent to my patient portal. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that Clover Family Medicine is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Clover Family Medicine has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing. I understand I can request a copy of my records in writing.

I request the following restrictions on the use and/or disclosure of my personal health information. I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I have been provided and have reviewed Clover Family Medicine's Notice of Privacy Practices dated September 8, 2021.

_____ X_____ _____

Print Name of Patient/Legal Representative Signature of Patient/Legal Representative Date

Consent to Release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Clover Family Medicine must have my written consent. Therefore, I authorize Clover Family Medicine to disclose my PHI as described on this form, to the recipients listed below:

Description of the information to be disclosed (check all that apply)

_____ Test Results _____ Appointments _____ Surgery Information _____ Billing Information

Name(s) of the person(s) authorized to obtain the above mentioned information:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature: X_____ Date:_____/_____/_____

Consent to Deliver Protected Health Information

With this consent, Clover Family Medicine may send **[_] mail, [_] e-mail,** or **[_] call** my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

Signature: X_____ Date:_____/_____/_____

Patient Policies

Acknowledgement

I have read and understand the above policies of Clover Family Medicine. I agree to the policies above and understand that I am responsible for payment for services I receive. This form must be signed to be seen at Clover Family Medicine.

_____ X_____ _____

Print Name of Patient or Legal Representative Signature of Patient or Legal Representative Date