Dr. Alan F. Bain DO
P: (312) 236 - 7010
F: (312) 236 - 7190

BAIN MED
DR. ALAN BAIN, D.O.

PRACTICE CONSENT

CONSENT AND POLICIES
PLEASE NOTE PAYMENT POLICY CHANGES EFFECTICE 6/1/2025

CONSENT TO TREAT

I hereby give my consent for Dr. Alan Bain, D.O. dba Bain Med (henceforth referred to as "the practice") to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition. I understand my physician may utilize a nurse to assist with my plan of care. If am currently utilizing other medical providers I understand that for Dr. Alan F. Bain, D.O., to make informed medical decisions concerning my care, he must have complete and uncensored access of my medical history and to those individuals that provided me with service.
I understand that for Dr. Alan F. Bain, D.O., to treat and or confer with me about my future/present/former healthcare, he must have unfettered access to my current/former medical records and by my signature below I am authorizing complete access.
I will provide Dr. Alan F. Bain, D.O., with names and numbers of all of my current medical providers and, if possible, the names and numbers and or locations of former medical providers, so that he may contact them and discuss their medical findings if deemed necessary.

I understand and I am informed that, as with all healthcare treatments, results are not guaranteed and there is no promise of cure.
I have had the opportunity to discuss with my provider the nature and purpose of treatments and procedures. I am aware that all existing methods of diagnosis and treatment pose some level of risk.

I do not expect the provider to be able to anticipate and explain all risks and complications, and I wish to rely on the provider to exercise judgment during the course of the treatment which the provider feels at the time, based upon the facts then known, is in my best interests.

I will immediately inform the provider if I experience any gastrointestinal upset (nausea, gas, stomachache, vomiting or similar condition), allergic reactions (hives, rashes, tingling of the tongue, headache or similar condition), or any unanticipated or unpleasant effects associated with treatment or supplements prescribed/recommended. **I understand that if an emergency medical condition arises, I am expected to call 9-1-1**

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TELEHEALTH CONSENT

In the event telehealth is necessary, I consent to voluntarily engaging in a telemedicine consultation with the practice. I understand that the video conferencing technology will not be the same as a direct patient/health care provider visit: Telehealth consultation has potential benefits, including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home. It also has potential risks including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. If there is another individual present during the telehealth consultation, I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through the practice will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all. Telemedicine services offered through the practice are not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to urgent care. To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

TELEPHONE CONSULTATION CONSENT

I understand that the practitioner / the practice may, on rare occasions, allow telephone consultations - verbal conversation only / no video. I understand that these consultations have considerable limitations, including but not limited to no physical exam or visual assessment. I understand that my provider, during the telephone consultation, may determine that adequate care and treatment will not be possible with the limited assessment via telephone consultation. I agree to follow through with them on any required in-person office visits or video telehealth visits. I consent to receive instructions via phone/telemedicine platform and take full responsibility to follow through with specific instructions as required for my treatment. I have had the opportunity to discuss the limitations with my provider.

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LABORATORY TESTS

I understand that Dr. Alan Bain, D.O. dba Bain Med (henceforth referred to as "the practitioner") / the practice may recommend blood, saliva, stool, urine, hair, or skin testing within their scope of practice. In addition to conventional testing, specific tests may be ordered through specialized laboratories to assess structural and/or functional deficiencies, and may not always be diagnostic, but can provide critical information to help improve my health outcomes. I agree with the use of such tests and will always have the opportunity to discuss their applicability and limitations with my provider, prior to sample collection. I agree to pay the laboratory any fees due for sample collection and processing to the lab and acknowledge that not all tests are covered by insurance or are FDA approved. I agree to follow up with my provider when my results are complete, even if they result "normal".

EMAIL USE CONSENT

The preferred method of communication is via HIPPA-compliant Patient Portal. However, the practitioner / the practice provides patients with the opportunity to communicate by e-mail if they prefer. Transmitting confidential health information by e-mail, however, has a number of risks: E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily copy information.

It is the policy of the practitioner / practice that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of the patient's protected personal health information. The practice cannot guarantee the security and confidentiality of e-mail or internet communication.

Patients may consent to the use of e-mail for confidential medical information after having been informed of the above risks with the following conditions: All e-mails to or from patients concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, insurance coordinators and, upon written authorization, other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.

The practitioner / practice will endeavor to read e-mail promptly. However, the practice can provide no assurance that the e-mail will be read immediately. Therefore, **e-mail must never be used in a medical emergency.**

Because some medical information is so sensitive that unauthorized disclosure can be damaging, e-mail should not be used for communications concerning diagnosis or treatment of any sexually transmittable or communicable diseases such as syphilis, gonorrhea, and the like; behavioral health,

mental health; or alcohol and drug abuse.

The practitioner / practice cannot guarantee that electronic communications will be private. The practitioner / practice is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct and is not liable for breaches of confidentiality caused by the patient.

I understand that my consent to the use of e-mail may be withdrawn at any time, whether it be by e-mail or written communication to the practitioner / practice**.** I have read this form carefully and understand the risks and responsibility associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail

APPOINTMENT REMINDERS CONSENT

The practitioner / practice may need to use my name, address, phone number, and my clinical records to contact me with appointment reminders/text message, information about treatment alternatives or other health related information that may be of interest to me. If this contact is made by phone and I am not available, a message will be left on my answering machine or with the person answering the phone.

By signing this form, I am giving the practice the authorization to contact me with these reminders and information and to leave a message on my answering machine or with individuals at my home or place of employment.

RELEASE OF INFORMATION

I may restrict the individuals or organizations to which your health care information is released or I may revoke your authorization at any time: however, this revocation must be in writing and mailed to the office address. The practice will not be able to honor my revocation request if they have already released my health information before the request to revoke authorization. In addition, if I was required to give my authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that the practice may use or disclose based on the authorization I am giving may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules. I have the right to refuse to give us this authorization. If I do not give authorization, it will not affect the treatment I receive or the methods used to obtain reimbursement for my care.

I may inspect or copy the information that is used to contact me to provide appointment reminders, information about treatment alternatives, or other health information at any time.

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This notice is effective on the date of signature. This authorization will expire seven years after the date on which I last receive services from the practice or if the patient submits a request to voice the authorization in writing. This can be sent to 444 N. Northwest HWY, STE 200, Park Ridge, IL 60068.

I authorize you to use or disclose my health information in the manner described above. I acknowledge that I have received a copy of this authorization.

FINANCIAL POLICIES -
THE SELF PAY FEES BELOW WILL BE BILLED DIRECTLY TO THE PATIENT IF THE PATIENT DOES NOT HAVE INSURNACE COVERAGE FOR THE SERVICE.
As the patient, it is in your best interest to know and understand your insurance plan benefits. It is important that you know your benefits prior to visiting. Regardless of your individual insurance coverage or type, as the person seeking medical treatment, you are ultimately responsible for all charges. By disclosing my insurance information, I authorize Dr. Alan Bain and/or his staff to bill your insurance for charges incurred during my physical visit, telehealth general or refill visit, or phone call visit. I understand I am fully responsible for any unpaid balances in which insurance does not cover or has applied to copayment/coinsurance/deductible/non-covered.

DISCOUNT SELF PAY | DIRECT PAY FEES:
A. NEW PATIENT PATIENT FEE (Initial visit):
- $200

B. ESTABLISHED PATIENT FEE (per visit):
- $150 (Complex Visit)
- $100 (Standard Visit)
- $50 (Refill visit)

C. HOMEOPATHIC | ALTERNATIVE MEDICINE (per visit):
- $227 (Standard Visit)

INSURED FEES (SUBMITTED TO INSURNACE):
A. NEW PATIENT PATIENT FEE (per visit):
- $328.22 (99205)

B. ESTABLISHED PATIENT FEE (per visit):
- $236.25 (99215, High Complexity)
- $182.32 (99214, Complex)
- $133.74 (99213, Low Complexity)
- $72.05 (99212, refill visit)

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C. **ANNUAL MEMBERSHIP (TELEHEALTH C.A.R.E. PLAN) SELF-PAY | DIRECT PAY**
- GOLD PLAN: $1524 Annual Fee or monthly payment plan ($127/month) - 4 Monthly telehealth visits
- SILVER PLAN: $600 Annual Fee or monthly payment plan ($50/month) - 1 monthly telehealth visit PLUS 50% discount on sick or extended visits
- Additional $20 fee for any visits scheduled in the office (per visit)
- Insurance billing waiver must be on file with this plan.

1. **IN PERSON OFFICE VISITS**
a. Co-Payments are due at the time of check-in. The office will generate a claim and file with your insurance carrier unless billing waiver is signed by patient.
b. Patients are responsible for any balance insurance allocates to “Patient Responsibility” and payment is due upon receipt of statement.

2. **PHONE CALLS**
a. Phone calls/messaging requiring 10 minutes or more of the provider's time will be charged as a minimum visit ($40)

3. **SPECIAL LETTERS, FORMS, and DOCUMENTS**
a. Completing special insurance forms, workplace documentation, writing letters of medical necessity, etc. require significant provider and administrative time and will be charged an administrative fee of $20 per document/letter. Fees must be paid in advance.

All services are paid by the patient at the time of service. You may pay by check, credit card, HSA card, or Flexible Spending Card.
We will provide you with a superbill with all the necessary codes, so that you may file for reimbursement with your insurance company, if necessary.

Patients are responsible for all remaining balances insurance assigns to patient responsibility. All outstanding balances must be paid in full prior to the next office visit or receiving supplements.

MISSED APPOINTMENT FEE

This office requires 24-hour if you are unable to keep your new patient or initial visit and 24-hour notice if you cannot keep your follow-up or routine visit. If you miss an appointment or fail to give sufficient notice, you will be charged $50.00 for that missed appointment. This payment is expected before any further treatment is provided, or supplements can be purchased. This fee is not reimbursable with insurance.

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RETURNED CHECK - There is a $20.00 fee for any check returned by the bank.

PAST DUE ACCOUNTS - If your account becomes past due, we will take the necessary steps to collect this debt. At the time of your initial office visit, a copy of your credit card will be taken. If your account becomes past due over **60 days**, that credit card will be charged.

SUPPLEMENT DISCLAIMER

Many supplements, vitamins, medical grade foods, nutritional powders, botanicals, and homeopathic remedies have not been evaluated by the US Food & Drug Administration (FDA) and these products are not intended to diagnose, treat, cure, or prevent any disease.

NO REFUNDS, CREDITS, OR EXCHANGES are allowed on any supplement(s), herbs, homeopathic remedy/remedies, vitamins, and nutritional supplements. Once these items have been purchased or left the office, they cannot be brought back under any circumstance.

All services and supplementation must be PAID IN FULL at the time of service. A remaining balance is not allowed.

- Supplements will not be held, picked up or shipped without prior payment.
- Special orders need to be paid for at the time of order. Once paid for, there will be no credits, refunds, exchanges, or modifications allowed.

Supplements may be bought directly from our trusted online dispensary (FullScript) or you can choose to purchase them at a dispensary of your choice. The cost of supplements is not included in the visit fee.

Please inform the practitioner if you are vegetarian and require vegetarian supplementation.

CREDIT CARD AUTHORIZATION

I authorize the practice to maintain my credit card number in the electronic health record and to use it to process payment for services rendered or supplements or other items purchased by me.

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I authorize the practice to process the credit card on file for any balance due on my account past **60 days** and for any payments authorized by me.

I understand that a receipt superbill and receipt showing what was paid for will be sent to me within 30 days of each visit. I know that I am responsible for informing the clinic regarding changes to my credit card information.

PRIVACY POLICY / HIPPA COMPLIANCE

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you with how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact the practice at 312 236 - 7010 or patientservices@docintheloop.com at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION:
The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

- **Treatment:** We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.
  For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

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- **Payment:** Your protected health information may also be used to facilitate payment or reimbursement to you from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.
- **Health Care Operations:** We may use or disclose your protected health information in order to operate this medical practice. These activities include training, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you be telephone, email, or text to remind you of your appointments.
  If we have to share your protected health information to third party "business associates" such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.
  We may also use and disclose your protected health information for marketing activities. For example, we might send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.
  We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.
- **Appointment reminders:** We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.
- **Others Involved in Your Health Care:** We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so at the time of your appointment. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need. If you prefer to have a designated person receive your PHI, please request a release of information to sign designating that person/s.
- **Research:** We will not use or disclose your health information for research purposes unless you give us authorization to do so.
- **Organ Donation:** If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.
- **Public Health Risks:** We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

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- **Health Oversight Activities:** We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.
- **Required by Law:** We will disclose protected health information about you when required to do so by federal, state and/or local law.
- **Workman's compensation:** We may disclose your protected health information to workman's comp or similar programs.
- **Lawsuits:** We may disclose your protected health information in response to a court action, administrative action or a subpoena.
- **Law Enforcement:** We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- **Access to medical records:** You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit complete and sign a request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you, if necessary. You may request this by emailing or calling our office.
- **Accounting of Disclosures:** You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" from the individual listed at the bottom of this policy. After your request has been approved, we will provide you with the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than (STATUTE OF LIMITATIONS) years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.
- **Restriction Requests:** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.
- **Confidential Communication:** You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

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- **Paper copy of this notice:** You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.
- **Complaints:** If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:
Dr. Alan F. Bain, D.O. - 444 N. Northwest Hwy suite 200, Park Ridge, IL 60068 | (312) 236 - 7010

PATIENT RIGHTS AND RESPONSIBILITIES

We are committed to serving you with compassion, care, and respect. As one of our valued clients, you are entitled to the following:

You have the right:

- To be treated with respect and dignity.
- To know the name and professional status of the person(s) serving you.
- To privacy and confidentiality.
- To receive accurate information about your health-related concerns.
- To know the effectiveness and potential side-effects of all forms of treatment.
- To participate in choosing the form of treatment best suited to your skin.
- To receive education and counseling about treatment.
- To review your medical record with your clinician.
- To receive any information about potential services or related services

You have the responsibility:

- To seek medical attention promptly and to provide useful feedback.
- To be honest about your medical and social history.
- To be honest about your lifestyle risks and exposures.
- To ask questions about anything you do not understand.
- To follow health advice and instructions.
- To report any significant changes in your health.
- To respect clinic policies.
- To show up for appointments or cancel 24 hours in advance.

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By signing this form, I certify:

- I have read this form or had this form explained/read to me
- I have read or had the Consents for Treatment explained/read to me. I understand its contents, including the risks and benefits of treatment, telemedicine, email use, and voicemail/text appointment reminders.
- I give my consent for treatment and accept all associated risks.
- I have read or had this Financial Policy explained/read to me. I understand its contents and agree with and accept the terms and requirements.
- I have read or had this Privacy Policy / HIPPA Compliance Policy explained/read to me. I understand its contents and agree with and accept the terms and requirements.
- I have read or had the Patient's Rights and Responsibilities explained/read to me. I understand its contents and agree with and accept the terms and requirements.
- I have had the opportunity to ask questions and have had them answered to my satisfaction.

Patient or Guardian Signature _____ Date _____

Patient Name (Please Print) _____

Patient Email _____ Patient Date of Birth _____