Akwaaba Care

HIPAA Privacy and Release of Information Authorization

Patient Name:_____

Patient email address:_____

Patient Phone Number:_____DOB:(MM/DD/YYYY)_____

Patient Full Address:_____

Patient SS Number:_____

I, _____hereby authorize Akwaaba Care, LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if its employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. I understand that protected health information may be used or disclosed for treatment, payment, and healthcare operations, including communication with insurance carriers regarding claims, benefits, and coverage determinations.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Signature of Patient or Legal Representative

_____

Printed Name Date

Akwaaba Care

Office Policies, Financial Policies and Billing Protocols

Welcome!

We are thrilled that you have selected Akwaaba Care for your healthcare needs, and we look forward to working closely with you to achieve your health goals. One of the most important aspects of such a working relationship is a mutual understanding of the financial responsibilities of the patient in relation to the services we provide and the policies of this office. Please read this document carefully, so that you may understand the boundaries, expectations, and protocols that govern this office and the patient-provider relationship.

Registration and Scheduling

Registration to become a patient in this office may take place over the phone or in person, and is considered complete when the necessary paperwork has been submitted and we have received your medical records from your previous PCP. Patients are expected to provide valid photo identification and a current insurance card(s) at every appointment, and images of those cards, front and back, will be recorded in your chart during the first visit. Failure to provide this office with a physical insurance card can impact our ability to submit orders, work claims and process referrals on your behalf.

After registering, a member of our staff will verify your eligibility to receive care. Eligibility, in and of itself, is not a guarantee that the services we provide will be covered by your plan. This determination can only be made when you notify your insurance provider that you have selected this office as your designated Primary Care Provider (PCP). Most insurance companies have very specific criteria that must be met before they will pay for medical care, and it is up to you to familiarize yourself with your plan's payment policies, thereby protecting yourself from being held responsible for charges that otherwise would have been paid for. Please remember that these criteria are not determined by this office and that we do not wish for anyone to be subjected to financial stress that comes from unpaid medical bills. The best way to avoid such difficulty is that we all do our due diligence and follow the guidelines that are set forth.

This office will bill your insurance plan in a timely manner and in accordance with all legal billing regulations and practices, but financial responsibility for services provided ultimately rests with you, whether or not you have valid insurance coverage. By allowing us to provide you with services, you are acknowledging this fact. When your plan or coverage changes, or if you experience a lapse in coverage, you are responsible for communicating this information with our office as soon as it occurs.

INITIAL HERE:_____

Primary Care Billing and Routine Office Visit Fees

We will bill your insurance company for all the services we provide, unless you choose a self-pay plan, in which case you will be responsible for your entire bill at the time that services are rendered. When we bill your insurance provider, the only fee you are responsible for at the time of the visit is any applicable co-pay or co-insurance rate, as determined by your health insurance provider, and any past due balance from a prior date or service. Our services may be provided in person, by telephone, or via telehealth, and legal billing regulations and standard billing practices will apply regardless of the means used to provide you with services.

INITIAL HERE:_____

Billable Provider Time and Visit Definition

Akwaaba Care bills for licensed provider time, whether it takes place in our office or outside of it. A "visit" may occur in person, by telephone, or via telehealth/video call, and is defined as time spent with a patient or their caregiver/healthcare proxy during which a licensed provider evaluates symptoms, provides medical advice, or makes clinical or non-clinical assessments or decisions based on the patient's history, medical needs, or at their request.

Billable provider services include, but are not limited to:

- Phone appointments and telephone calls involving medical evaluation and follow-up.
- Telehealth encounters (audio or video), whether they are scheduled or unscheduled.
- Clinical discussions with the provider that are related to symptoms, diagnoses, treatments or procedures.
- Clinical evaluations such as the review of a patient's chart, symptom and/or condition assessment, medical history evaluation, or other form of medical decision-making process that is required to achieve the best possible health outcomes for the patient, or that is requested by the patient.
- Clinical evaluation or medical decision making that leads to the prescribing of new medication.
- After-hours, weekend, or closed-day medical consultations via telephone or otherwise.

If a provider responds to a patient's medical concern, reviews a patient's medical record and history, and makes a clinical decision on behalf of said patient, *this constitutes a billable visit*, even if the patient is not physically present. Administrative services such as scheduling, billing questions, or prescription refills that are approved *without provider evaluation* are *not* billable visits.

INITIAL HERE:_____

INSURANCE COVERAGE

Medicare: The office will bill the Medicare intermediary.

Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge and any non-covered services
- Any covered service ordered by the provider which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicare Replacement Plans: we accept some MRP's, but not all. The question of whether we can accept a replacement plan must be addressed prior to the patient's first visit with us. These plans are evaluated on a case-by-case basis and inquiries should be made to our front desk staff well in advance of the proposed visit.

Mass Health: We are contracted to provide services to *Mass Health members who have the PCC Plan only.* This plan is a division of Mass Health Standard and is the only form of Medicaid we accept. We do not accept Fallon, Medicaid plans from other states, or Mass Health Limited. Patients must provide the Practice with a current Medicaid card at each visit.

INITIAL HERE:_____

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service, as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Many plans require patients to designate a Primary Care Provider (PCP). Failure to properly designate Akwaaba Care or its providers may result in denied claims or increased patient responsibility.

In the event of a denied claim, this office will do everything possible to attempt to obtain reimbursement from the insurance carrier, in a manner that is consistent with best practices depending on the reason for the denial. If the denial cannot be reasonably worked or appealed and resolved within 30 days, the remaining outstanding balance will be transferred to patient responsibility. Denials directly resulting from the patient's failure to comply with the policies outlined in this document, will result in outstanding balances transferred to patient responsibility upon confirmation of the cause for denial. If a patient is not prepared to pay their co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the provider. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, verification of the patient's out-of-state or out-of-network benefits will take place prior to their scheduled appointment. Alternatively, the patient may pay for services out of pocket at the time they are rendered and then seek direct reimbursement from their insurance company.

INITIAL HERE:_____

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third-party carrier benefits to be paid directly to Akwaaba Care, LLC, realizing I am responsible for any resulting balance. I also authorize the provider to release any information required to process this claim to my insurance carrier. I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount may be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

INITIAL HERE:_____

ELECTRONIC CHECK CONVERSION: When providing a check as payment, I am authorizing Akwaaba Care to use information from the check to make a one-time electronic fund transfer from my account or to process the payment as a check transaction. I understand that funds may be withdrawn from my checking account the same day. Returned checks will be assessed a fee of $55 per incident.

INITIAL HERE:_____

CONSENT FOR TREATMENT: I hereby authorize the providers, nurses, medical assistants and other Practice staff of Akwaaba Care, LLC to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable. I understand that procedures and treatments that were not planned ahead of time may be determined medically necessary and I grant the provider full authority to perform such procedures as they see fit. I understand that this may result in charges billed separately from the office visit fee.

INITIAL HERE:_____

I have read and understood the policies and statements outlined above, and hereby agree to them:

SIGN:_____

PRINT NAME:_____

DOB:_____

Today's Date:_____

IF PATIENT IS A MINOR:

Printed Name of Parent/Guardian:_____

Signature of Parent/Guardian:_____

Patient DOB:_____

Today's Date:_____

CHECKLIST

- **Registration forms completed and submitted via upload form on website**
- **Call insurance plan to change PCP to Akwaaba Care Family Practice, NPI: 1407477151 or Samuel Boateng, CRNP, NPI: 1790162527 (please note that some plans will have our practice name or medical group on file, Akwaaba Care, and some will have Dr. Sam's name and individual provider details on file; this varies, but as long as they allow you to select one of the two as your PCP you should be covered)**
- **Determine expected co-pay for an office visit, and for an annual exam, if any**
- **Confirm that your previous Dr's office has sent us your medical records (the release form is on our website and our fax # is 833-989-2289)**
- **Take picture of health insurance card, front and back, and submit them via the upload form on our website, or email to the images to becky@akwaabacare.com for registration**
- **Have your physical insurance ready to bring to your first appointment. If you do *not* have the card you may call your insurance company to get a digital copy, or go to their website, where you should be able to log in, view your policy and print the cards**
- **Valid Photo ID ready for first appointment**
- **Financial, Privacy, Hippa and Office Policies Document Complete, along with any other documents or health related information that you wish to share with us or add to your chart**