Akwaaba Care

HIPAA Privacy and Release of Information Authorization

Patient Name:_____

Patient email address:_____

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

Patient Full Address:_____

_____

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.

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

Financial Policies and 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 component of the working relationship that we will cultivate is a clear explanation of your financial responsibilities in relation to your medical care, and therefore we would like to briefly outline our financial policies.

Patients are expected to provide valid identification and a current insurance card(s) at time of registration. Registration may take place prior to the appointment over the phone or in person at the time of the visit. Patients are financially responsible for all services provided and are expected to pay for those services at the time of service, including co-pays and any past due balance from a prior date of service.

After registration is complete, insurance eligibility will be verified by a member of our staff.

If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship.

Returned checks will be subject to a $45 fee.

Primary Care and other routine in-home visit fees: We 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. If we bill your insurance provider, the only fee you are responsible for at the time of the visit is your regular co-pay as determined by your health insurance provider.

Missed appointments: If you need to cancel or reschedule your appointment kindly do so greater than 24 hours prior to the appointment. Last minute cancellations for telehealth appointments or routine primary care will not incur cancellation fees unless they become a regular occurrence on the part of the patient. In the event of a No-Call/No-Show in-home visit (house call) the patient will be held responsible for a fee of $150.

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
- Any non-covered services
- Any covered service ordered by the physician 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.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services.

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.

Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. 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, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

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.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a onetime electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

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, the undersigned, understand the Financial and No-Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

Name:_____DOB:_____
Todays Date:_____

Signature of Parent/Guardian if Minor:_____