PATIENT CARE AGREEMENT / FINANCIAL POLICY

Patient Name: _____ **Date of Birth** (mm/dd/yyyy): _____

Social Security Number: _____ **Phone Number:** (_____) _____

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the medical care and treatment tendered to the patient as deemed necessary or advisable in the judgment of the Integrity Primary Med, LLC ("Integrity Primary Med") physician or other health care provider. I understand that, prior to rendering treatment, the Integrity Primary Med physician or other health care provider will explain my medical care and treatment, including an explanation of treatment alternatives and the indications, benefits, and risks associated with such treatment. I acknowledge and consent to the following:

1. **AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS:** I hereby expressly authorize Integrity Primary Med and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to Integrity Primary Med and all professionals providing for such care, and I hereby assign such sums to them. I understand this authorization and assignments shall remain valid unless I provide written notice of revocation to Integrity Primary Med and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
2. **NOTICES OF PRIVACY PRACTICES:** I acknowledge I have access to a copy of Integrity Primary Med's Notice of Privacy Practices. A copy of Integrity Primary Med's Notice of Privacy Practices is posted in the office and a copy is located on their patient portal https://26277.portal.athenahealth.com. I understand I may request a copy of this policy for my records.
3. **PATIENT SAFETY NOTICE:** I acknowledge that Integrity Primary Med may obtain/have access to my medication history and record sharing in Athena (electronic medical records). This includes record sharing ability with Lee Health and Millennium Physician's Group and import of historical lab data from LabCorp and/or Quest. Additionally, I have been informed that Integrity Primary Med has a Covering Provider Agreement with an outside physician for consultation purposes and provider communications are via HIPAA secured means. Integrity Primary Med furnishes only outpatient medical care, and should I require care in the hospital Emergency Department and/or admission to the hospital, I understand that the covering provider may be involved in my care at that time.
4. **NOTICE OF PHONE CALL RECORDINGS AND PHOTO RELEASE:** This serves as notice that all phone calls to and from Integrity Primary Med, may be recorded. By signing, I hereby grant permission to Integrity Primary Med to record any phone calls I make to or receive from their office. Additionally, I grant Integrity Primary Med, its representatives, and employees the right to take photographs of me. I agree that Integrity Primary Med may use such photographs of me, with or without my name, for any lawful purposes, specifically patient identification for medical records and/or injury/wound identification and tracking.
5. **PAYMENT FOR SERVICES:** I agree to pay Integrity Primary Med for services rendered. **Copayment/coinsurance and/or deductible fees are due at the time of visit, otherwise appointment may be rescheduled.** If I have medical insurance in which Integrity Primary Med participates with, Integrity Primary Med will submit a claim to that insurance carrier. I understand that my insurance coverage is a contract between me and my insurance company, not Integrity Primary Med. If my insurance carrier classifies the charges as a deductible, co-payment, and/or coinsurance or denies payment for noncovered services, that balance becomes the patient's responsibility. All services that have outstanding balances 90 days from the date of service will also be deemed my responsibility. Any outstanding balances **are due within 30 days** of the statement. **The second and each subsequent statement shall accrue interest at the rate of 10.5% per calendar month**. If you experience circumstances beyond your control, please call our office and **we will be happy to make payments arrangements**. All balances reaching 90 days past due may be sent to a collection agency. **Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the delinquent balance.**
6. **NEW CARD ON FILE FEATURE:** As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is scanned and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes the checkout process easier, faster, and more efficient. We have implemented a similar policy at our practice. You will be asked for a credit card at the time you check-in, we will scan the card in our system, and the information will be held securely until your insurance has paid their portion and notified us of any additional amount owed by you. At that time, you will receive a notification that the remaining balance owed will be charged to your credit card, and you will receive a receipt for the charge. This will be an advantage to you, since you will no longer have to receive statements, write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out, and reduce the difficulty in following up with patients, allowing us to focus on more important issues, like your care. The combination will benefit everybody in helping to keep the cost of health care administration down. This new program will in

no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

7. **ADMINISTRATIVE SERVICES, CHARGES, AND PATIENT RESPONSIBILITIES:** Due to the continued decline in reimbursement from insurance companies and their failure to pay for the following services, we are no longer able to absorb the cost of these services. Therefore, the following administrative services will be billed directly to you with payment being your responsibility. All such fees must be paid prior to scheduling future appointments.
   a) **Appointment Cancellations / Missed Appointments** - Broken appointments represent not only a cost to us, but also an inability to provide service to others who could have been seen in the time set aside for you. We require 48 hours' notice of cancellation to avoid a cancellation fee. The cancellation fee is **$50**. It is your responsibility to remember your appointment. We do not guarantee that reminder calls/texts will be made in advance.
   b) **Prescription Refills** - New prescriptions will not be issued without first seeing your physician. Prescriptions for acute care or chronic conditions are written with an appropriate number of refills to complete the course of treatment or to last you until your next scheduled appointment. Regular follow-up appointments are required to ensure continued safe medication refills and/or potential medication adjustments. You may be charged **$25** for any additional refills issued without seeing the physician or to replace a lost prescription. Refill requests without an appointment will be limited to a maximum 30-day supply. Controlled medications will not be refilled without an appointment. All prescription requests are taken only during office hours and filled within 48 hours. An additional 24-48 hours may be required if a request is submitted the day before a long holiday weekend.
   c) **Prescription Prior Authorizations** - We will honor prior authorization requests from the patient, but the patient is responsible for contacting their insurance company to have them forward the prior authorization form to our office. A **$25** fee will be assessed for time to complete the prior authorization form. The fee must be paid before the prior authorization will be completed. Any request for a forced change in your medication by your insurance company will require an office visit. The patient will need to ask their insurance plan what "alternative medications" are covered and provide a list to their Physician.
   d) **Letters/Forms Completion** - Completion of patient forms (for example FMLA request, return to work release, etc.) take time to complete and document in your patient record. At the discretion of the Physician, letters and forms requiring medical review and physician signature are subject to additional fees. Fees for these services vary based on complexity and range from approximately **$50** to **$250.** This fee must be paid prior to the forms being completed.
   e) **Telephone Consultations / After-hours Calls** - Telephone consultations/after-hours calls for medical advice/treatment may be subject to a fee that is billed directly to you. Fees for these services vary based on complexity and range from approximately **$50** to **$250** per call.
   f) **Requests for Medical Records** - In accordance with Florida law, **Integrity Primary Med** requires written requests for the release of medical records. The administrative fee associated with retrieving and copying medical records is based on current Florida law and is dependent on the number of pages requested. Please take this into consideration when requesting copies of your medical records.
8. **HOMEBOUND PATIENT CARE:** Homebound services are available to patients currently enrolled in Primary Care Services with Integrity Primary Med if they qualify according to the CMS / Medicare definition and they reside in an area that can be serviced by Integrity Primary Med. Patients who receive care in their private residence (CMS billing POS 12) are subject to a **$75 private residence trip fee/cancellation fee**. This is not a covered Medicare expense and is the patient's responsibility. All balances that are a patient's responsibility will be charged to the credit card or bank account on file. There are no refunds of any kind relating to the trip or cancellation fee including any prepayments. Private residence trip fee does not apply to patients who receive care in an Assisted Living Facility (CMS billing POS 13) or Group Home (CMS billing POS 14).
9. **OUT OF NETWORK CARE / SELF PAY:** Please be aware that you have an option to seek care from physicians even though they are not participating in your insurance network. In this situation, your out-of-pocket expense will be greater than if you seek care from an in-network physician. As a courtesy to our out-of-network patients, we will file your insurance claim if desired. However, all out-of-network patients will be charged the current Medicare allowable for services rendered. Payment is due at the time of service. This benefit also applies to individuals without insurance.
10. **CHRONIC CARE MANAGEMENT SERVICES:** Integrity Primary Med provides Chronic Care Management services (as defined by the Centers for Medicare and Medicaid Services) and the undersigned agrees to receive these services. The undersigned recognizes that only one healthcare provider may bill for these services in a calendar month, they may cancel services in writing at any time and there may be additional fees not covered by their insurance associated with these services. The undersigned also authorizes the electronic communication of their medical information with other treating providers as part of care coordination. A copy of the care plan can be obtained at any time by contacting the administrative office of Integrity Primary Med.
11. **CONTROLLED SUBSTANCES:** I acknowledge that the controlled substance that I may be prescribed now or in the future has a potential for physical dependence. I agree to take this medication only as prescribed and will not at any time change the amount or frequency of the medication without the consent of my provider. Running out early, needing refills, escalating doses without permission, and losing prescriptions will be viewed as signs of misuse and could be grounds for discontinuation of the medication

and/or discharge from the practice. I understand lost, stolen, or damaged medications will not be replaced. I will not sell or lend my medications to any person. I will not drink alcohol or take illegal substances. I understand that any controlled substance prescription provided to me will result in checking of the Prescription Drug Monitoring Program (PDMP) database as required by Federal and/or State Law. I understand that use of long-term Controlled Substances (greater than 7 days) is done at the discretion of the provider and may necessitate a referral to an outside specialist for management. I understand a separate Controlled Substance Agreement is required for any controlled substance that requires a refill.

12. **TELEMEDICINE CONSENT:** Telemedicine is the delivery of healthcare services when the healthcare provider and you are not in the same physical location using technology. Electronically transmitted information may be used for diagnosis, therapy, follow-up, prescription refills and/or patient education and may include medical records, medical images, interactive audio, video and/or data communications, and output data from medical devices and sound and video files. You agree that your primary care provider or any healthcare professional assigned to your care will determine whether your condition being diagnosed and/or treated is appropriate for telemedicine. All information collected will be treated as protected health information and subject to HIPAA rules.
13. **TELEPHONE NOTIFICATIONS:** You are consenting to receive messages from Integrity Primary Med, your healthcare provider, which utilizes an automatic telephone dialing system to deliver a text, voice, or pre-recorded message that may contain health related information or healthcare management advice at the telephone number(s) that you provided. You understand that you are not required to provide consent to receive such information or advice from your healthcare provider.
14. **HIPAA CONSENT:** The Department of Health and Human Services has established a "privacy rule" or "HIPAA", to help ensure that personal information is protected and secure. You have the right to refuse or consent to the use or disclosure of your personal health information, but this must be submitted in writing. Under HIPAA, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI), as it would preclude our ability to give you safe, thorough, and proper care. You may at any time, request to refuse disclosure of all or part of your PHI. Actions that have already been taken reliant on this signed form, or a previously signed consent, cannot be revoked. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.
15. **ALLOWED HEALTH INFORMATION DISCLOSURE:** No information will be released about you to anyone without your consent. To communicate with the office or know anything about my healthcare, you authorize individuals listed below to have access to your health information. This section left blank means you do not want anyone to have access to your information.

Patient's Email address for online Patient Portal communications: _____

Patient Authorized HIPAA Contacts:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this document, I certify that I have read, understand and agree to its contents and that the information provided by me is accurate and complete. A copy of this document may be utilized the same as the original.

Patient / Legal POA [Print]: _____

Patient / Legal POA [Signature]: _____ **Date** [mm/dd/yyyy]: _____

If not signed by patient, please provide documentation of legal POA status: Attached: [ ] Do not have copy: [ ]

PATIENT'S NAME (Print): _____ DOB: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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