

2026 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 physician or other health care provider will explain my diagnosis and recommended treatment, including an explanation of the indications, risks, benefits, and alternatives to 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 to such care directly to Integrity Primary Med and all professionals providing 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 the Notice of Privacy Practices. The Notice of Privacy Practices is available in the office and is also available on the patient portal at <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 the electronic medical record. This includes record sharing ability with other local healthcare providers and/or access to outside records such as Lee Health (Epic), etc. and import of historical lab data from third parties such as Quest and/or LabCorp. Additionally, I have been informed that Integrity Primary Med has a Covering Provider for consultation purposes. 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 to 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 all services rendered. **Co-payment, deductible, or cost sharing fees are due on the date of service, otherwise appointment may be rescheduled.** If I have medical insurance in which Integrity Primary Med participates, a claim will be submitted to that insurance carrier. I understand that my insurance coverage is a contract between me and my insurance company, not Integrity Primary Med. If the insurance carrier classifies the charges as a deductible, co-payment, and/or coinsurance or denies payment for services, that balance becomes the patient's responsibility. All outstanding balances greater than 90 days from the date of service will also be deemed patient responsibility. Any outstanding balance is 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 and associated fees.**
6. **NEW CARD ON FILE FEATURE:** You will be asked for a credit card at the time you check in. Your card will be scanned and stored in an encrypted format by our processing service. The information will be held securely until your insurance has paid their portion and notified us of any amount owed by you. At that time, you will receive a notification that the remaining balance will be charged to your card in approximately 7 days. You may choose to pay the balance by an alternative method before it is posted to your card. The card on file feature will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment. In addition, the card on file may be charged for administrative fees as outlined.
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 / Adjustments** - New prescriptions, prescriptions not previously written by our provider(s), or dose adjustment to a prescription will **not be issued outside an appointment**. Prescriptions for acute 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 safe medical care and/or potential medication adjustments. You may be charged **\$25 per prescription** for any additional refills requested outside of a visit. Refill requests without an appointment will be limited to a maximum **30-day supply**. Controlled medications will **NOT** be refilled without an appointment. **CONTROLLED MEDICATIONS ARE REGULATED BY LICENSING AGENCIES AND THERE WILL BE NO EXCEPTIONS**. All prescription requests are usually filled within 72 hours. An additional 48 hours may be required if a request is submitted before a long holiday weekend.
 - c) **Prescription Prior Authorizations** - An **administrative fee** will be assessed for time to complete the prior authorization (PA) paperwork. The fee must be paid before the prior authorization will be completed. The cost will range from **\$30** for simple requests up to **\$350 (or current hourly rate)** based on complexity and the amount of physician time necessary to complete the required paperwork. **THIS DOES NOT GUARANTEE THAT YOUR INSURANCE COMPANY WILL APPROVE THE REQUEST**. The patient will need to ask their insurance plan what "alternative medications" are covered and provide a list to their Physician. Alternatively, you may elect to have the PA completed during a **SUBSEQUENT** visit. We are unable to complete PAs at the same time as an initial visit as the completed visit note is required to be uploaded as part of the prior authorization process.
 - 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 vary based on complexity, time to complete and range from \$50 to **\$350 (or current hourly rate)** when done **outside a visit**. This fee must be paid prior to the forms being completed. Please allow a minimum of **five business days** for completion of this request.
 - 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 provider time including documentation time and range from \$50 to **\$350 (or current hourly rate)** 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.
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 are subject to a **\$150 monthly private residence trip fee/cancellation fee**. This is not a covered Medicare expense and is the patient's responsibility. There are no refunds of any kind relating to the trip or cancellation fee including any prepayments. This fee does not apply to patients who receive care in an Assisted Living Facility where the provider has previously established patient care.
9. **OUT OF NETWORK CARE / SELF PAY:** Please be aware that you have an option to seek care from a physician 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, we will file your insurance claim if desired. However, all out-of-network patients will be charged the current **HOURLY RATE** for services rendered and we are not obligated to accept assignment. Payment is due at the time of service. Reimbursement will be sent to the patient directly from his/her insurance company. It is your responsibility to follow up on claims submitted to non-participating insurance companies. Claim payments made to our billing service are sent to PO Box 32422, Belfast, ME 04915-0217 and can take up to 2 weeks to post. If benefits are inadvertently sent to our billing service, we will reimburse the amount we have received after we have confirmed receipt of funds.
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. Fees for this care are subject to insurance co-pay, cost-sharing, and/or deductible. 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 controlled substances that I may be prescribed now or in the future have 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 consent of my provider. Running out early, escalating doses without permission, and/or 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 excessive alcohol or take illegal substances at the same time as my controlled medication. I

understand that any controlled substance prescription provided to me will result in checking 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. A current non-expired driver's license or government issued photo ID card is required to receive controlled substances.

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, that 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 the 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, 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. **HOSPICE CARE:** Integrity Primary Med will remain your PCP (Primary Care Provider) once you are admitted to Hospice Services. Hospice services are free for patients; however, Integrity Primary Med will bill Medicare for Part B benefits – we do NOT provide Hospice care. Currently Hospice providers in the local area include Hope Hospice and Vitas Hospice. For patients with a Medicare Advantage plan (PPO), your primary insurance will be changed to traditional Medicare (Red, White, and Blue card) which covers 80% of allowable charges. This means that 20% co-insurance will be the patient's responsibility including charges for Chronic Care Management.
16. **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: _____

UPDATED 01/01/2026.