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Assignment of Benefits

Assignment of Benefits

I hereby assign payment directly to accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by my insurance company or for any and all charges which the insurance carrier declines to pay. It is further agreed that my credit balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician(s) by the insured or his/her family.

Release of Information

The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to the Health Care Financing Administration and/or the patient's attorney for all or part of the physician(s) charges including but not limited to patient insurance companies, worker's compensation carriers, welfare funds or the patient's employer if a worker's compensation case.

Lifetime Authorization

Medicare and Medicaid Patient Certification – Payment Classification Authorization to Release Information and payment Request: I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare, Medicaid, or other third party claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and co-insurance.

Please Note

Insurance contracts are made between you and the insurance company. We do not render service under the assumption that the charges will be paid by your insurance company. Payment of any and all charges is presumed to be your responsibility. All charges are due in full upon receipt of our statement. A photocopy of this form shall be valid.

_____ _____

Printed Name of Patient or Responsible Party *Date*

_____

Signature of Patient or Responsible Party

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Insurance Billing Authorization Form

This form authorizes Evolve Restorative Center to use or disclose your patient health information to bill Medicare, Medi-Cal, Partnership, workers' compensation administrator, or your private insurance company for office visits, clinical care, evaluations and/or medical procedures.

"I request that payment of authorized Medicare, Medi-Cal, Partnership, workers' compensation, and/or other insurance benefits be made on my behalf to Evolve Restorative Center for services provided me by Evolve Restorative Center, its agents, and employees. I authorize any holder of medical information about me to release to Evolve Restorative Center, Medicare, Medi-Cal, Partnership, workers' compensation administrator, and/or any other insurance company including its agents and employees, any information or documentation needed to determine these benefits or the benefits payable for related services."

"I understand my signature requests that payment be made and authorizes release of medical information necessary to secure payment for the claim. If I have supplemental health insurance coverage, my signature authorizes releasing the medical information to the supplemental insurance company, its agents, and employees. This signature authorization shall remain in effect until revoked by me in writing."

"I understand that Evolve Restorative Center is HIPPA compliant and I have the right to request a copy of Evolve Restorative Center's Privacy Notice and to review it before signing this authorization form. A photocopy of this authorization is to be considered as valid as an original."

"I understand that I am financially responsible for appointments and procedures that are not cancelled with proper advance notice, per the guidelines of Evolve Restorative Center and understand that I may be asked to provide specific documentation such as a physician's note for illness."

BILLING YOUR INSURANCE DOES NOT GUARANTEE PAYMENT. THE AMOUNT PAID BY INSURANCE CANNOT BE GUARANTEED. YOU ARE RESPONSIBLE FOR THE PAYMENT OF YOUR BALANCE.

_____

Signature of Patient or Responsible Party

_____ _____

Printed Name of Patient or Responsible Party *Date*

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HIPAA Authorization (per the Health Insurance Transfer and Liability Act)

For Use or Disclosure of Health Care Information.
By signing this form, I authorize the use and disclosure of my medical information described below:

They can release my medical information in the following ways:

- ☐ leave a message via voicemail
- ☐ leave message with spouse and / or caregiver
- ☐ fax information to my residence and / or workplace
- ☐ send information by mail or my residence and / or workplace
- ☐ provide information through the Evolve web portal

You can leave messages to confirm appointments as follows:

- ☐ leave a message via voicemail
- ☐ leave message with spouse and / or caregiver
- ☐ provide information through the Evolve web portal

Other than yourself name of the specific person (s) to have authorization to receive this information:

_____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) when the use or disclosure has already been made in accordance with my original consent or (2) the authorization was obtained as a condition of guaranteeing medical coverage and for law the insurer has the right to challenge a claim or the insurance policy. I understand that use and disclosure already made based on my original authorization cannot be undone. To revoke this authorization, I must do so in writing and send the revocation to: Evolve Restorative Center, 220 Concourse Blvd, Santa Rosa, CA 95403,

_____

Signature of Patient or Responsible Party

_____ _____

Printed Name of Patient or Responsible Party *Date*

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RESTORATIVE CENTER

Consent to Receive Telehealth Services

We at Evolve Restorative Center recognize there are circumstances that can make it impractical or impossible to see you in-person in a face-to-face visit. In those circumstances, we may offer telehealth as a means to continue to provide needed healthcare services. You always have the option to receive services in-person in a face-to-face visit, or you may have the option to receive services via telehealth. The decision to use telehealth for your healthcare is a decision to be agreed upon by you and your healthcare provider. If you have trouble accessing in-person services due to transportation, your insurance may provide coverage for transportation services when other resources have been reasonably exhausted. There may be limitations or risks related to receiving services through telehealth rather than in-person. The ability to accurately diagnose and treat your condition may not be viable by utilizing telehealth services and could delay care as a result. If we feel that an in-person visit is required, we may reschedule your visit or request a follow-up visit to be performed in-person. If you have any questions about this document or how we provide services via telehealth, consult with your provider at Evolve Restorative Center.

In order for us to provide the option of telehealth for healthcare services, now or in the future, you must acknowledge and agree to the following:

1.I agree to receive healthcare services via telehealth. I understand that:

- I have the right to access covered services through an in-person, face-to-face visit or through telehealth.
- The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.
- My insurance may provide coverage for transportation services to in-person services when other resources have been reasonably exhausted.
- There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit. For example, accuracy of diagnosis may be limited, potential treatment may be inaccessible, and my care may be delayed.

2. I have read this document carefully, understand the potential limitations and risks of receiving services via telehealth, and have had my questions answered to my satisfaction.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Patient or Responsible Party

EVOLVE

RESTORATIVE CENTER

We are honored to have the opportunity to help care for you in helping manage your functional and pain care needs. Clear and timely communication is critical and can be frustrating when expectations are not met.Our mission of “where kindness meets best practice,” guides our patient engagement, straving to meet each and every patient connection with empathy and precesion. It is with this mind that we want to provide visibility and confidence on how we communicate with you outside of your scheduled appointment. We are here for 24 hours a day, 7 days a week. Every day.

Phone System

Live Answer

- Our dedicated phone team strives to and consistently answers at least 80% of the phone called received durning normal business hours of 8:00 am to 5:00 pm PST Monday through Friday
- For quality assurance, each outgoing and incoming call phone call is recorded and logged daily
- You will be transferred to the appropriate department corresponding, procedure or surgery scheduler , billing, or managent
- For calls requiring medical judment, we will message your provider directly for instructions on how best to treat you

Messages

- If we are unable to answer the call, you will be prompted to leave a message and we will return your call within 4 business hours
- To better ensure that you receive all calls from our office please add our number to your contacts

Answering Service

For all after hours calls, you will be prompted to leave a message. We encourage you to leave your name, the best call back number, and the purpose of the call. Every call is recorded, transcribed, and sent to a secure messaging center for our on-call provider. The calls will be returned in the order they are received and or the urgent nature of the call.
For emergencies, please hang up and call 911 or go to your neartest emergency room

_____ _____

Signature of Patient or Responsible Party *Date*

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OPEN PAYMENTS NOTICE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient or Patient's Representative

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We appreciate the opportunity to partner with you in the management of your functional and pain care needs. In that effort, we want to provide the most expeditious care possible and to underscore our mission of "Where Kindness Meets Best Practice." While unexpected things arise, no shows and late cancellations can impact our ability to provide care timely.

Cancellation/ No show policy

Office Visits (Telemedicine, Virtual, or In-Person)

72-hour advance notice required for cancellations and reschedules

- $250 charge will be assessed if less than 72-hour notice given for rescheduling fee
- This includes "No shows" after
- Multiple no shows or late cancellations are subject to discharge from practice
- Exceptions include illness with a doctor's note, etc.

Procedures/Injections/Surgery

- 7-day advance notice required for cancellations and reschedules
- $350 charge will be assessed if less than 7-day notice given for rescheduling fee
- This includes "No shows"

Physical Therapy

- $40 Charge if No Show/Late Cancellation without 48 hour notice for return visit appointments
- $50 charge if No show first time Evaluation
- Exceptions for sudden illness are allowed and video visits offered in lieu of in-person appointment to avoid cancellation

In order to continue to provide our patients with exceptional care please keep all scheduled appointments and expect up to a 2 hour wait.

_____ _____

Signature of Patient or Responsible Party *Date*

Notice of Privacy Practices

EVOLVE
RESTORATIVE CENTER

220 Concourse Boulevard
Santa Rosa, CA 95403
www.evolverestorativecenter.care
707.271.5443
privacy@evolverestorativecenter.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, within 15 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 30 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

01-17-2024

This notice applies to Evolve Restorative Center Clinics and Evolve Physical Therapy. We never market or sell personal information. We will never share any substance abuse treatment records without your written permission.

Director of Compliance and Risk Management
privacy@evolverestorativecenter.com
707.271.5443

EVOLVE RESTORATIVE CENTER
220 CONCOURSE BOULEVARD
SANTA ROSA, CALIFORNIA 95403
(707) 271-5443

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____