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Bohemian Concierge Care Retainer Agreement

Patient Name: _____ Date: _____

Welcome to a new world of healthcare and wellness, we are glad to have you as a member of ***Bohemian Concierge***. As part of your concierge membership, we offer a wide variety of services that are tailored to meet your goals, and values. At Bohemian Concierge Care we strive to provide the most up to date treatment options that will benefit you. The following document helps prevent confusion about your responsibilities in treating your medical condition. The agreement below explains those services and how we will work together. Please read the below information carefully before signing. If you have questions, please contact the front office 707-509-5961.

Services:

In person office visits. Patient appointments are generally available within one week. We will always schedule sufficient time to thoroughly discuss your healthcare. Emergency visits can be scheduled the day of if your provider is available. The Urgent Care is also an available resource if your provider is unable to see you.

Telephone visits:

Doctor Flower believes that in person visits offer the highest quality of care; therefore visits will take place in office. Dependent on circumstance and necessity, your doctor may decide a phone visit is appropriate.

Appointment hours:

M/W/F: 10am-4:15pm

T/Thurs: Appointments 10am-12:15pm

T/Thurs: Walk in appointments available for urgent matters are between 1pm-4:15pm (Lab, and imaging reviews require a set appointment time)

Annual Exam:

Your health and longevity are best served by frequent Office Visits. Therefore, we will perform a thorough annual examination to monitor existing health conditions and recommend preventative treatments.

Out of Office Ancillary Services:

Your care may require out of office services such as, laboratory tests and imaging. These services will be separate from your concierge fee and office visit.

Specialty Care Coordination:

If your care requires the services of a medical specialist outside of our office, we will make every effort to source the appropriate referral as quickly as possible for you. Once the specialist consultation is complete, we will continue to work with your specialists to coordinate care with our office. While Hospitalist services are not part of your membership, if you are admitted to the hospital, we will collaborate with the providers to facilitate the best care available. Payments: You remain financially responsible for all co-payments, co-insurance and/or deductibles as defined by the terms of your insurance coverage for provision of covered services.

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You remain financially responsible for all co-payments, co-insurance and/or deductibles as defined by the terms of your insurance coverage for provision of covered services.

Patient/Provider Communication:

Bohemian Concierge asks that you contact the front desk for all communication with your physician. Our front desk team will schedule appointments, start medication refills, coordinate referrals and function as liaison between you and your Doctor. You can reach our front desk during business hours at (707)509-5961.

Retainer Fee Agreement:

Bohemian Concierge will not seek reimbursement from any insurer, Medicare, or other third-party payer for the Retainer Fee. You are solely financially responsible for payment of the Retainer Fee and agree not to submit the Retainer Fee to Medicare or your private insurance carrier, except for reimbursement from your health savings account ("HSA"), medical savings account ("MSA") or Flexible Benefits Account ("FBA") if allowed. (We suggest you check your benefits for this) You and/or your insurer shall be financially liable for all covered services provided by the Practice and or Access Health and you or your insurer will be billed for these services.

Annual Retainer Fees:

Individual: $2000 ***Pair/Couple (Same household)***: $3000

Quarterly Fees:

Individual: $500 ***Pair/Couple:*** $750

You may elect to pay the Annual Retainer Fee on a quarterly basis. Each quarterly installment fee ($500 per quarter, per individual, $750 per quarter per couple) will be automatically charged to your credit card on or following the first day of each quarter. A link will be sent to your email to enroll you in quarterly payments, and your card information will be stored in our secure system. A card must remain on file to be eligible for quarterly payments. If you pay annually, this can be done via cash, check, or credit card. Access Health does not currently charge a credit card processing fee, but such fees may be put into place in the future. ***Cash and check are always appreciated***. The annual payment is due on your renewal date. If you decide to pay via check, the check should be sent out before your renewal date to avoid any late fees. If you choose to pay via credit card, please note that your card will be automatically charged on or the following day of your renewal date. A link will be sent to your email to enroll you in automatic payments.

****There is no membership charge for children of patients in the same household under 26 years old.****

Renewals and Terminations:

Renewals:

The term of this agreement is one year from the effective date. The agreement will renew for everyone on the 1 (one) year anniversary unless written notice is given a minimum of 30 days prior to anniversary date. The Renewal Fee is due on or before the 1 (one) year anniversary date. If you have a card on file your renewal fee will automatically be charged one day after renewal date. Terms and conditions of the agreement may be changed by written notice to you at any time by Bohemian Concierge Care may terminate this agreement at any time.

Terminations:

Failure to pay renewal fee can result in termination of your membership with Bohemian Concierge. Bohemian Concierge Care will make 3 attempts to collect payment. If no payment is made by the third attempt the membership will be placed on hold. If no payment is made within 45 days of due date the membership will be cancelled. The missed payment will still be due, and can be sent to collections.

Voluntary Termination of Membership:

If any member of the Concierge Practice would like to terminate their membership a 90-day notice will need to be provided in writing. If you paid your membership in full at effective date a prorated amount can be refunded to the member. If you are on the quarterly payment plan no refund will be given. However, you will not be charged for your next payment and can continue to be seen in the practice until the end of the paid term.

Consent to Treat:

You acknowledge, consent and hereby authorize Bohemian Concierge Care and its providers to carry out your healthcare treatment. Treatment includes, but not limited to, the administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medications, the performance of such procedures as may be deemed necessary or advisable for treatment, including but not limited to diagnostic procedures, the taking and utilization of cultures, and of other medically accepted laboratory tests, all of which in the judgment of your physician or their assigned designees may be considered medically necessary or advisable. You acknowledge and understand that this consent is given in advance of any specific diagnosis or treatment, that these services are voluntary, and that you have the right to refuse these services. You understand and intend this consent to be continuing in nature, even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving your revocation.

By signing below, you have read, acknowledge, and agree to all terms and conditions listed above.

Please circle your selected membership plan:

Individual: Annual or Quarterly **Pair/Couple**: Annual or Quarterly

Patient Signature: _____ Date: _____
Print Name: _____

Additional Members: _____ DOB: _____
Relationship to signing Member Additional Members: _____ DOB: _____

Physician Signature: _____ Date: _____

1. While membership is on hold patients cannot be seen through the Concierge Practice.
2. If terminated by the practice, you will receive one copy of your medical records and a prorated refund if you are on the annual payment plan.
3. Please send your new physician a medical release form to have your records forwarded to their office. One copy of your records will be provided to your new physician at no cost. However, any additional copies of your records may have a $25 fee.
4. Refund amount will be based on the amount of time spent with the Bohemian Concierge Care.

At Bohemian Concierge Care we strive to provide the most up to date treatment options that will benefit you. The following document helps prevent confusion about your responsibilities in treating your medical condition.

Financial Responsibility:

You are responsible for all costs of your treatment. Your insurance may, or may not cover all the cost associated with the plan of care pursued by you and your physician. All copays are due at time of service. As a courtesy to you, we will bill and collect the amount allowed by your insurance contract for your treatment. We are not responsible for insurer's inadequate payment, unreasonable payment delays or claim denials. We do our best to make sure planned treatments are preauthorized for; however, we advise that you verify your insurance benefits before undergoing any treatments, procedures, or surgical intervention. Please be aware that certain services are not typically covered under the scope of routine office visit by your Insurance.

Return Check Fee $50

Late Arrival Policy:

Please be aware that if you are greater than 15 minutes late to your appointment, you may be asked to reschedule your visit, or you may have to wait until we can fit you in after on-time arrivals have been seen.

Appointment No Show $50

Cancellation Policy:

If you need to cancel your appointment, please contact the office 24 hours before your scheduled time. We understand that 24hrs notice may not always be possible; however, we will still require a minimum of 2hrs notice to cancel your appointment. If we do not receive sufficient notice a Late Cancellation Fee can be charged to your account.

Same day Cancellation Fee $50

Phone Call Policy:

Our office receives a tremendous amount of phone calls each day. In order to devote the appropriate care, and attention to each patient in the office, our physicians and/or office staff typically return calls promptly. The medical board of California discourages physicians from providing treatment information over the phone; therefore, if you are experiencing a new problem, please schedule return visit to discuss the issue in person. If you are experiencing a ***life threatening emergency, please call 911***. In general, we are not available to discuss issues over the phone with multiple family members. If you believe you will have difficulty

remembering treatment recommendations discussed during your visit, please bring a family member to assist with note taking, and recollection.

Acknowledgement of our Notice of Privacy Practices and Consent to Obtain Prescription History

I agree that Bohemian Concierge Care may request and use my Medication History from I hereby healthcare providers or third-party pharmacy benefit payers for treatment purposes. ***Bohemian Concierge*** acknowledges that I have received or have been given the opportunity to receive a copy BCC Notice of Privacy Practices (A laminated copy is available at the front desk. Additionally, I may request a hard copy at any time).

By signing below, I am giving acknowledgment that authorizing I have received or have had the opportunity to receive the Notice of Privacy Practices. I am also giving permission to release and or discuss my healthcare information with the following persons.

Patient Signature: _____

Print Name: _____

Date: _____

Authorized Persons: _____

Signature: Print Name: _____

Relationship to Patient: _____

Date: _____

Insurance Release Policy:

I hereby authorize the release of any medical information necessary to process an insurance claim. I understand that I will be responsible for all non-covered services, including out of network charges, and any denial not covered by my medical insurance program.

Medication Refill Policy:

You are responsible for keeping track of your own medications. Please allow 3-4 business days' notice to be refilled on all prescriptions. Please call our office directly for prescription refill requests. By signing below, you or your pharmacy, or other providers' authorization to communicate verbally, electronically or in writing regarding your current medications.

Pain Medication Policy:

In addition to the above Medication Refill Policy, these guidelines also apply to controlled substances: all controlled substance prescriptions must be picked up in person with photo ID. All prescriptions for controlled substances must be filled by one medical office at one pharmacy. Evidence of substance by more than one medical office or using multiple pharmacies for controlled prescriptions without prior substance disclosure is grounds for discontinuation of controlled substance refills, by Bohemian Concierge Care office. By accepting a discussed prescription from our offices, you grant our physicians, and staff permission to medically aspects necessary. Of your care and medications with all involved physicians, hospitals, and pharmacies as above.

By signing this document, I acknowledge that I have read, understand, and accept the policies noted

Patient Signature: _____

Print Name: _____

Date: _____

Authorized Persons: _____

Signature: Print Name: _____

Relationship to Patient: _____

Date: _____

Controlled Substance Contract

Patient Responsibility

1) I agree to take any Controlled Substances exactly as instructed. I am NOT allowed to change the dose or number of times per day that I take my medication without first talking to my Controlled Substances Provider. _____ (initial)

2) I agree to only take Controlled Substances prescribed by _____ (your provider at MYW) _____ (initial)

3) I will not take Controlled Substances written by another provider or specialist unless I have notified my provider prior to filling the prescription. _____ (initial)

4) I agree to safekeeping my Controlled Substance prescriptions and medications. I understand that lost, misplaced, or stolen prescriptions or medications will not be replaced. _____ (initial)

5) I will bring in all my Controlled Substance medications in their original pill container to every appointment _____ (initial)

6) I will bring in all Controlled Substance medications in their original pill container for random pill counts when requested _____ (initial)

7) I will NOT combine any narcotic medication with consumption of alcohol. Any UDS that is positive for both Controlled Substances and alcohol will be considered a violation of this contract. _____ (initial)

8) I will NOT combine any narcotic medication with illegal/street/recreational drugs. Any UDS that is positive for both prescribed Controlled Substances and illicit substances will be considered a violation of this contract. _____ (initial)

9) I will be responsible for making and keeping appointments for Controlled Substance refills at least every 3 months. I understand that NO refills will be written outside of my appointment and I will NOT contact the office for refills of these medications. _____ (initial)

10) I will be responsible for having a working phone number which the office will use to contact me about random UDS and pill counts. I understand that once notified by the office, either directly or by voicemail, I will have 24 hours to report, or inability to do so will result in a violation of this contract. _____ (initial)

11) I understand that not all insurances cover the cost of Drug Screening and that I may be responsible for part or the entire bill. _____ (initial)

12) I understand that I will not receive any Controlled Substances until my provider has been able to review my medical records. If I am a new patient, I understand that it is my responsibility to ensure my medical records have been obtained from my previous provider. _____ (initial)

13) I will not lie or tell misleading information to my provider or any of the MYW staff. _____ (initial)

14) I will not get angry or make threatening remarks in an attempt to get Controlled Substances _____ (initial)

15) I agree to come to the clinic for a face to face office visit at least every 3 months _____ (initial)

16) I agree to being seen by any of the providers at MYW _____ (initial)

Provider Responsibility:

1) Provide the best evidence-based care for your condition based on the type of pain you have
2) Help set functional and pain control goals with you
3) Obtain a random drug screen at least once a year (may be from blood, urine, saliva based on provider discretion)
4) Refill controlled substances at your designated medication refill appointment, unless deemed medically unnecessary or inappropriate.
5) Obtain at every appointment a report from CURES which shows all controlled substances you have been prescribed including:
    1. Who wrote the script
    2. Which pharmacy filled the script
    3. What medication, dose and quantity were filled
6) Assess the risk/benefit/safety of your medications including:
    4. Side effects
    5. Functional abilities
    6. Pain control

Consequences of NOT adhering to any part of this Contract:

1) Our office/providers will no longer:
    a. Prescribe any controlled substance for you. It will be at provider discretion to decide if a taper of medication will be given.
    b. May stop providing medical care for you
    c. May refer you for drug abuse treatment

Consequences of NOT signing this contract: We will not prescribe controlled substances for you.

Should you be discharged from our practice due to breakdown of provider/patient communication, your provider will provide 30 days of care from the date of discharge. This may not apply to Controlled Substances if the reason for discharge was a violation of this contract.

Patient Name: _____

Patient Signature: _____ Date: _____

Provider Name: _____

Provider Signature: _____ Date: _____