ENCLAVE
FAMILY HEALTHCARE

Office Policies and Procedures

We want to welcome you and sincerely thank you for choosing us as your primary care provider. We are committed to providing you with the highest quality in healthcare. In order to be able to continue to provide such care it is necessary that we address several points and ask for your support as it relates to responsibilities and expectations of our patients. Please read these policies, feel free to ask us any questions you may have, and sign or initial where indicated. A copy of these policies will be placed in your personal Enclave "Be Healthy" Record for your future reference. *Please be sure you read and understand all of the following.*

1. **Consent to Treat.** I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, medications and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

   Initial_____

2. **XANAX (Alprazolam)** is no longer prescribed to new/incoming patients in our office regardless of circumstances.

   Initial_____

3. **Financial Agreement.** I understand that all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure the insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs. Collection fees will equal 50% of the amount turned over for collection. Reasonable attorney fees incurred to effect collection of this account or future outstanding accounts will be the responsibility of the patient. We do offer a 30% discount off of our regular fee schedule for any of our "in house" medical services for anyone who elects to pay in full at the time of their visit. Please note: this discount is available to anyone regardless of insurer.

   Initial_____

4. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan that we do business with payment in full is expected at the time of service. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit will be required until we can verify your coverage. Knowing your insurance benefits is your responsibility (our staff cannot keep up with all the changes of every plan for every patient). Please contact your insurance company with any questions you may have regarding your coverage.

   Initial_____

5. **Release of Medical Information and Authorization to Pay Insurance Benefits.** I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of

insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial_____

6. **Co-payments and Deductibles.** 100% of all co-payments and deductibles must be paid at the time of service. This arrangement is part of you contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients could be considered ***fraud***. Please help us in upholding the law by paying your co-payment at each visit.

Initial_____

7. **Non-covered Services.** Please be aware that some – and perhaps all – of the services you receive *may be uncovered or not considered reasonable or necessary* by Medicare or other insurers. To the extent that this is known, you must pay for these services in full at the time of the visit. Should lab or other testing outside the office be required, those entities will bill your insurance carrier or make arrangements directly with you. Once again, be aware that some – and perhaps all – of these services may be non-covered or not considered reasonable or necessary by Medicare or other insurers.

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8. **Proof of Insurance.** We must have complete patient information on all of our patients before seeing the healthcare provider. We obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. As an additional service, we do provide the ability for our patients to complete this information online before their visit – please ask our staff for details. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Initial_____

9. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Initial_____

10. **Medicare Certification.** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my provider who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorized benefits be made directly to my physician treating me, on my behalf.

Initial_____

11. **Medigap (Medicare supplement) Authorization (Medicare Patients Only).**
    Name of Beneficiary (Patient) _____
    Medigap Policy Number_____
    I am giving Enclave Family Healthcare, PLC permission to ask for Medigap payments for my medical care. I understand that _____ (name of Medigap Insurer) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to _____ (name of Medigap Insurer). I request that payment authorized by Medigap

benefits be made either to me or on my behalf to Enclave Family Healthcare, PLC for any services furnished to me by that physician/supplier. I authorize any holder of medical information to release to _____ (name of Medigap Insurer) any information needed to determine benefits payable for related services.

Signed _____ Date _____

12. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Initial_____

13. **Non-Payment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to an attorney or collection agency for collection and you and your immediate family members may be discharged from the practice. If this should occur, you will be responsible for all costs of collection including court costs, reasonable interest, reasonable attorney's fees and reasonable collection agency fees. You will also be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period our provider will only be able to treat you on an emergency basis.

Initial_____

14. **Missed Appointments.** We want to ensure all of our patients who need our attention have to opportunity to receive it, so unless cancelled or rescheduled at least *24 hours* in advance, our policy is to charge $50 for missed office visit appointments and $75 for missed procedure appointments. Also, we do not feel we can partner with you adequately to positively impact your health if appointments are missed therefore, if you do not cancel 24 hours in advance or no-show for your scheduled appointment 3 times in a 12 month period you will be dismissed from our care. In the event your insurance carrier contractually does not allow such charges, 2 missed appointments will result in dismissal.

Initial_____

15. **Returned Checks.** For any check that is returned due to insufficient funds you will be charged a $30 returned check fee.

Initial_____

16. **Telephone/Secure Email Release.** I give my consent and authorization for medical or billing staff of my physician's office to leave protected healthcare information about me or for me on my answering machine, voicemail (via the telephone number I have listed below) or email (via the email address I have listed below). I understand I may revoke this privilege at any time by submitting my request in writing to this office

Phone Number _____
Initial_____

Email Address* **_____**

By entering email address you are indicating your wish to gain access to Enclave's Patient Portal and agree to gain access for purposes of non-urgent communication with Enclave. In the event you lose access you are to notify our office, otherwise this will remain a viable route of communication at all times. This is a HIPAA compliant, secure online site.

Who may we leave test results or discuss your healthcare with if unable to contact patient or parent?

Name/Relationship_____/_____ (if no one, so state)
Initial_____

Advanced Directive

- Do you have a living will? Yes___ No___ I'd like to discuss___
- Have you appointed a healthcare representative? Yes___ No___ I'd like to discuss___
- Have you given anyone your Power of Attorney? Yes___ No___ I'd like to discuss___
- Do you desire Resuscitation (life support)? Yes___ No___ I'd like to discuss___

Our practice is committed to providing the absolute best diagnosis and treatment possible to our patients. Our prices are representative of the usual and customary charges for our area. If you have any questions about our office policies and/or procedures please ask our office staff and they will be happy to answer any questions you may have.

I have read and understand the office policies and agree to abide by its guidelines. I acknowledge that I have received the Notice of Privacy Practices*.

_____ _____

Signature of Patient or Responsible Party **Date**

***If patient did not sign, give reason and initial** _____