Boca Integrative Health, PA

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OFFICE POLICY STATEMENT
Agreement to its Terms of Treatment

Please read these policies *carefully* before initialing- by initialing or by not initialing but receiving care after having had opportunity to read them, you are agreeing to all of our terms of treatment!

Thank you for visiting our office. As a patient of *Boca Integrative Health, PA*, you will enjoy medicine the way it should be practiced- with the goal of developing a strong doctor-patient bond and the good health that relationship creates. We work hard to create a positive and educational environment, and your comments are always welcome! Please also be aware of the following office policies.

OUR GENERAL POLICIES

CONFIDENTIALITY: Issues discussed during the course of evaluation, treatment or therapies are confidential. No information will be released to anyone (including third party payers, physicians, schools, etc.) without written consent from the patient, or if a minor, by the legal guardian of the patient. Often, third party payers will request information from the provider of services in order to determine eligibility for reimbursement. Please be sure to ask your insurance carrier about the type and amount of information that they might request before giving your written consent. It is important to understand that the release of confidential information with or without consent is required in situations of potential harm to oneself or others, in instances where the court may subpoena records and in cases of suspected child abuse. Whenever possible, you will be notified in advance prior to any such disclosure. The laws of the State of Florida require health professionals to report suspected cases of abuse (physical and/or sexual) and neglect to appropriate agencies.

ETHICS AND PROFESSIONAL STANDARDS: The doctor is committed to uphold the most responsible ethical and professional standards possible and is accountable to you. If you have any questions or concerns about your course of treatment please discuss them directly with her. By obtaining services here, you are agreeing that should you have any dissatisfaction or concerns about your evaluation or treatment or should you wish to change your medical provider, you will do your best to indicate that you are making a change and why you wish the change to be made. If you need help finding additional or alternative assistance, the doctor will do her best to help you locate a more suitable referral. If, during the course of your care and treatment, you have any questions about the nature of your treatment (i.e. goals, procedures, etc.) or our billing practices please feel free to ask.

OFFICE HOURS: Generally, Monday through Friday, 9-5 and we offer some evening hours as well.

TELEPHONE CALLS: The doctor is available (on a call back basis) to patients for a short (5-10 minutes) telephone consult, however, telephone calls should not be used as a substitute for an office visit. Significant telephone calls will be billed by the doctor at the doctor's sole discretion.

EXTENDED SESSIONS (Dr. Rome and Jodi Weissman's patients): From time to time, particularly when an important issue is being explored, a session extends longer than originally planned or scheduled. Because psychiatry fees are based on time, in those instances when the session does run long the patient will be charged accordingly.

PRESCRIPTION REFILLS: Prescription refills are best obtained while you are at the office for an appointment and some circumstances do require this. However, in some cases, medications can be refilled in between appointments with the doctor's approval. Please provide 72 hours notice before you will run out of medication. *No refills will be filled on weekends, holidays or after hours*. **AGAIN, expect 72 hours for all phone refill requests and plan accordingly.**

IN-OFFICE PRODUCTS: As a medical professionals, the doctors research and are knowledgeable about certain products that they believe promote good health and recommend those products to patients. The price we charge offsets our costs of providing the product, and we do make a small profit on the purchase. However, the purchase of these products is a recommendation only, not a medically necessary prescription, and your use of the product is entirely up to you. If you wish to purchase the product you may do so either from our office or from another provider.

EMERGENCIES: ***In case of an emergency, call 911 or go to the nearest Emergency Room!*** If you need to speak with someone urgently, please try the office telephone number. If you reach voicemail follow the instructions to leave an urgent message. If you reach a secretary/receptionist, urgent calls will be relayed to the doctor as soon as possible. The doctor will be in touch as soon as she is able. In the event you are unable to reach the doctor quickly enough and you feel your needs have become emergent please go to the emergency room of your local hospital.

OUR FINANCIAL POLICIES

NON-INSURED PATIENTS (including patients whose insurance we do not accept): Non-insured patients are expected to pay in full with cash, check or credit card the day service is rendered unless specific arrangements are made in writing in advance.

WE DO NOT ACCEPT MEDICARE! If you have Medicare, please come to the window and speak with our staff.

INSURED FAMILY MEDICINE PATIENTS: we accept assignment of benefits. This means that you must sign the portion of your insurance form that "assigns" payment to our office. *Most medical insurance plans DO NOT COVER 100% of the cost of your treatment.* Because of this and the extreme delay in receiving payment from the insurance company, *you will be asked to pay your copay, deductible and/or coinsurance the day service is rendered*.

We will *estimate* as closely as possible your coverage, but until we actually receive payment from the insurance company, *it is just an estimate*. We will *assist* you in dealing with your insurance company, but the ultimate responsibility for payment lies with you. After 45 days, any remaining balance not covered or received from your insurance company will be due in full from you.

KNOW YOUR INSURANCE- you are responsible for your insurance policy! Due to the vast variety of policies *even within the same insurance company*, and the constant changing of policies, we cannot be responsible for interpreting each individual policy. We will verify that you have a current and active insurance policy only. Therefore we urge you, the patient, to know your personal coverage and its limitations, as well as who is a provider on you plan. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred. Please remember that your insurance policy is a contract between you and your insurance company. **It is your responsibility to know, or find out, whether or not we are providers for your specific network.**

FORENSIC, REPORT OR LETTER FEES: Fees for reports or letters for disability insurance, employer, school, etc. will be based on the time required by the doctor for preparation. If the doctor must be involved in litigation because of professional services provided to you please note that *the forensic fee will be different from the regular in-office fee. A retainer must be paid in advance based on an estimate of the minimum time that will be required for the services. Out-of-office services will be charged on a portal to portal basis.* The forensic fee will be applied to all services connected to the litigation, including but not limited to telephone conferences, depositions and court appearances. A forensic fee schedule is available, if necessary.

NON-COVERED SERVICES (patients for whom we accept insurance): We provide medical care according to what our doctors believe is in the best interests of our patients- not what insurance companies believe is in our patients' best interest. Therefore, some recommended services may not be covered by insurance. You agree to pay for non-covered services (we will always try to tell you in advance is a service isn't covered).
_____ (initial here)

CANCELLATIONS and MISSED APPOINTMENTS: ***Twenty-four (24) hours notice of cancellation of an appointment is required for all appointments***. *Failure to keep the scheduled appointment or failure to cancel an appointment more than twenty-four (24) hours in advance will result in a charge of the normal fee for the expected service. Monday appointments must be canceled by* 10AM on Friday *to avoid this charge.* In addition, in those cases where your visit is paid by a third party payor, you are personally responsible for cancelation charges even if the third party payor does not pay. _____ (initial here)

NOTE: Patients responsible for keeping their own appointments but not responsible for payment; 1st no show – the person responsible for payment will be called to inform them that they are paying for an appointment you failed to show up to. 2nd no show – you will be responsible for payment in cash for missed appointment before you can be seen by the doctor again.

OFF-HOURS FEE: In trying to meet the needs of our patients, we may offer you an appointment outside of our normal business hours. This appointment may carry an additional fee. You understand and agree that is a non-insurance-covered convenience and administrative (non-medical) charge and that you have the option of scheduling an appointment during normal business hours without incurring the additional fee. You agree to pay this fee, up front, and understand that **this is in addition to any copay, deductible or other normal charge.**
_____ (initial here)

COLLECTION FEES and COSTS: There will be a fee for returned checks and thereafter payment must be made with credit card or cash. In addition, in the event we must institute collection and/or court proceedings to collect unpaid fees (including missed appointments), you agree to pay, in addition to the outstanding fee, our costs and the value of any attorneys services incurred in the collection of those fees or any part thereof. Our settlement for a smaller amount than we initially demand shall not constitute a waiver of our right to recover full fees and costs.
_____ (initial here)

Statement of understanding: Please ask before signing below or obtaining treatment if you have any questions about our office policies. Your signature below, or your receipt of services after having had an opportunity to read these policies and terms, constitute your agreement to our office policies.

I have read this contract and agree to its terms.

_____
Printed name of patient

_____ _____
Signature of patient/guardian/guarantor Date

_____
Printed name of guardian/guarantor

Boca Integrative Health, PA

Consent for Purposes of Treatment and Healthcare Operations (HIPPA)

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. BOCA INTEGRATIVE HEALTH, PA is not required to agree to the restrictions that I may request. However, if BOCA INTEGRATIVE HEALTH agrees to a restriction that I request the restriction is binding on BOCA INTEGRATIVE HEALTH.

I understand I have the right to review BOCA INTEGRATIVE HEALTH's Notice of Privacy Practices prior to signing this document, in accordance with HIPAA. The BOCA INTEGRATIVE HEALTH Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in performance of health care operations of BOCA INTEGRATIVE HEALTH. This notice of privacy practices also describes my right s and the duties with respect to my health care information.

My "protected health information" means health information, including my demographic information, collected from me or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information may identify me.

The following are waivers to confidentiality. Unless otherwise specified in writing, you agree to the following limited waives and release of confidential information:

1. **To the professional who referred you to our office. You agree that we may contact the individual or agency who referred you and may convey the following information: (a) the fact that you have been seen and evaluated; (b) treatment initiated and anticipated length of treatment; (c) your prognosis; (d) fitness for employment and participation in employment or treatment; and (e) updates as needed.**

2. **For medication consultation. You agree that we may consult with your other healthcare providers. You authorize the release of information from your healthcare provider to me and vice versa to facilitate such consultation.**

3. **For consultation with other medical professionals. From time to time, we may discuss with other medical professionals regarding a clinical issue. The medical professionals are bound by laws and confidentiality. You authorize the release of information we believe reasonably necessary to such a consultation. Generally, identifying data will not be released to the consulting clinician.**

4. **To hospitals or agencies accepting the patient for medical or mental health care.**

5. **To your insurer or its agent, or to any collections company, court or other entity, to the extent we believe necessary to obtain reimbursement or payment.**

I have read and had any questions satisfactorily answered:

_____ _____

Signature of Patient or Parent/Guardian Date