Rivers to Wellness
PRIMARY CARE

OFFICE POLICY

PATIENT INFORMATION

*If you provide your e-mail and/or cell phone to us, we may use such information to contact you by email and/or text for appointment reminders, waiting lists, missed appointments and marketing of services provided by Rivers to Wellness.

APPOINTMENT INFORMATION

In consideration of our patients, you may be asked to reschedule if you do not arrive on time for your appointment.

NOTE: If you determine you need to cancel or reschedule your appointment, please contact our office with a minimum of 24 hours in advance of your scheduled appointment time. Failure to comply with this policy will result in a $50.00 charge. These charges are not submitted to, nor covered by, insurance, and therefore becomes your responsibility. All No-Show fees must be paid before a new appointment can be scheduled. Repeated missed appointments may result in the loss of future appointment privileges.

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Rivers to Wellness. I am responsible for any applicable deductible, co-pay, or co-insurance prior to the provision of services. Rivers to Wellness will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each visit, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. Rivers to Wellness may file a claim for payment with my insurance company as a courtesy to me. I understand I am responsible to notify Rivers to Wellness if I have a secondary insurance. If the insurance company fails to pay Rivers to Wellness in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Rivers to Wellness. Payment may be made to our office in the form of Cash, Check, Debit and Credit Cards. In the event that I receive a check directly from my insurance company payable to me for services rendered by Rivers to Wellness, I understand that this payment belongs to Rivers to Wellness. I agree to endorse the back of the check and promptly deliver the check to the Practice.

Rivers to Wellness
PRIMARY CARE

Patient credits are applied to other outstanding patient balances prior to any refunds that may be issued. I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fees. I may also be charged if I do not cancel my scheduled appointment, or for not paying my patient responsibility including deductible, co-pay or co-insurance at the time of service.

COLLECTION AGENCY AND DISHCHARGE FROM RIVERS TO WELLNESS

Should my account be referred to a collection agency or attorney for collection, I shall pay all costs of collection, including a reasonable attorney's fee. Balances not paid in full or payment arrangements scheduled within 60 days of the initial statement are considered delinquent and Rivers to Wellness Billing Office will charge a collections fee of $25.00 and place the account in inactive status. Patients who do not pay their outstanding bills within 90 days of the initial statement will have their account put on hold until the outstanding balance is paid in full.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE

I understand that it is my responsibility to provide Rivers to Wellness with a copy of my current insurance card. If I do not have insurance, I will be considered a Self-Pay Patient and be financially responsible for the total amount of the services provided. I will notify Rivers to Wellness immediately upon any change in my insurance.

INSURANCE WAIVER, NON-COVERED SERVICES WAIVER AND OUTSIDE LAB SERVICES

I understand that if I do not have a copy of a current insurance card, Rivers to Wellness is not obligated to see me. But if I still wish to be seen, I will be considered a "Self-Pay" patient. I agree that neither Rivers to Wellness, nor I, will file a claim for the visit. I will be required to pay the total cost of the visit in advance. In addition, there may be a service I desire, suggested, or provided that is not covered under my insurance plan "Non- Covered Services"; I understand that I must pay for the Non-Covered Services. A waiver will be completed for each Self-Pay visit or Non-Covered Service. I understand services sent to an outside lab are billed to my insurance or me by the outside lab and I will receive a separate invoice from the outside lab.

PATIENT COMMUNICATION AUTHORIZATION

My signature and choices noted below verify my acknowledgement of the following:

- I understand the risks associated with voice, online, email, and text message communications between my provider/provider's staff and me, and consent to the conditions outlined herein.
- Commonly used email services are not secure and fall outside of the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information.

Rivers *to* Wellness
PRIMARY CARE

- In consideration for my desire to use electronic communication as an adjunct to in-person office visits with my healthcare team, I hereby consent to electronic communication via both secure-encrypted and non-secure email services.
- I understand that I may revoke or alter my consent to communicate electronically at any time by notifying Rivers to Wellness in writing, but if I do, the revocation will not have an effect on actions my healthcare provider or team has already taken in reliance on my consent.
- I have been given the opportunity to discuss electronic communication with a representative of Rivers to Wellness and have had all my questions answered. I agree and release my provider and practice from any and all liability that may occur due to accidental misuse of electronic communication over both secure and non-secure networks.

CONSENT TO TREAT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, and any and all medication which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment.

TELEMEDICINE CONSENT

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving information may be used for diagnosis, therapy, follow-up and or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols and protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

1. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation
    - Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals using interactive video, audio, email, and telecommunication technology.
    - Video, audio and/ or photo recordings may be taken of you during the procedure(s) or service(s)
2. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this or information

Rivers to Wellness
PRIMARY CARE

for this telemedicine interaction to researchers or other entitles shall not occur without your consent.

3. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation.
4. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
5. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Florida, and Florida law shall apply to all disputes.
6. RISKS, CONSQUENCES & BENEFITS: You have been advised of all the potential risks, consequences, and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

ANNUAL EXAMS

Annual exams are preventative visits and may not be paid for by all insurance carriers. I understand that I am responsible for payment if the exam or portion of the exam is not covered by my insurance.

Annual exams do not include problems I may be having. If I am experiencing problems, the issue will be addressed by the provider and the service will be billed to my insurance company. I understand that I may be billed for a deductible, co-pay or co-insurance as shown on the explanation of benefits received from my insurance company.

COMPLETION OF FORMS & RELEASE OF RECORDS

There will be a $30 charge for the completion of forms, i.e., insurance disability, FMLA paperwork, etc. A charge of $1.00 per page for the first 25 pages and $.25 per page thereafter for copy of records requested by the patient. Records must be picked up in person by the patient. Records requested by out-of-town patients will be sent via certified mail with an additional fee of $10.00.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to Rivers to Wellness. I understand that I am financially responsible for all charge not covered by my insurance plan.

Rivers *to* Wellness
PRIMARY CARE

ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to Rivers to Wellness. I hereby authorize Rivers to Wellness to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare.