Girls to Women HEALTH AND WELLNESS

Young Men's HEALTH AND WELLNESS

Patient's Legal Name: _____ **Date of Birth ____/____/_____**
(18+ years of age)

OFFICE POLICIES

Due to our unique medical practice approach, some of our policies or procedures may be different than a typical doctor's office.

TYPES OF MEDICAL VISITS.

When requesting an appointment, please be clear which type of visit you want so that we can allow adequate time to meet your needs.

- **Preventive/Wellness Visit.** Recommended once a year, this is a time to review general well-being, update the status of chronic medical conditions, update immunizations, determine laboratory testing needed, and discuss developmentally-based health education. Your provider will perform a thorough physical exam and complete any routine athletic physical forms if needed. This visit does not include addressing new problems, prescribing new medications or making changes to current prescriptions.

- **Problem/Follow-up Visit**. This visit includes evaluation, treatment and/or follow-up of health issues, problems and/or concerns. Due to the complex needs of our patients, some visits may require extended time (additional fees may be billed). You will be responsible for the additional fees not covered by insurance.

- **Combined Preventive/Wellness plus Problem/Follow-up Visit**. If BOTH types of services are provided in one appointment, both services will be billed. Some insurance companies do not pay for both services on the same day; you will be responsible for the additional fees not covered by insurance.

- **Telemedicine Visit** is a scheduled appointment conducted over a secure two-way video platform (healow App on your mobile device) between the patient and the medical provider. This appointment is billed as a problem/follow-up visit.

APPOINTMENTS.

- A missed appointment is a missed opportunity to ensure your health and wellness. Appointment reminders are sent by email and text. Please confirm or reschedule your appointment as needed. Whether a reminder is received or not, you are still responsible for remembering your appointment date and time. Please make sure to provide updated contact information. If you are not able to keep an appointment, we would appreciate no less than 24 business hours cancellation or reschedule notice. If notice is not received, no show, late cancellation or reschedule fees will apply.

- We know that your time is valuable and make every effort to minimize your wait. Please understand that every patient has unique needs and that some may require more time than was planned. Thank you for understanding and know that we will give you extra time when you need it as well. However, if you arrive late to your appointment, we do our best to accommodate you. You may encounter a longer wait time or the appointment may need to be rescheduled (and a late cancellation fee will be charged).

MEDICATION REFILLS.

Most prescription refills require a scheduled office visit to assess and possibly modify treatment.

- Please ensure that your follow-up medical visit occurs prior to running out of medication. If you do miss an appointment, please call to re-schedule your appointment. Check your medication supply to ensure the re-scheduled appointment will occur before you need a refill.

- We do NOT honor refill requests from pharmacies, and we do not provide refills after normal business hours. Please allow approximately 3 business days to process a refill request; there may be a processing fee for medication refills handled outside of an office visit.

COMMUNICATION.

Urgent Phone Calls (during regular business hours). Calls received during business hours will be assigned according to clinical priority for response as soon as possible. If you are directed to our voice mail, please leave a detailed message to help us prioritize your call. Other phone calls will be responded to within 1-3 business days.

After-Hours Phone Calls. Call our main number after hours for instructions. We expect that unless it is a true emergency (call 9-1-1), you will call the on-call provider to discuss recommendations prior to heading to the ER or Urgent Care. After-hours calls are for emergency issues only.

Voice/Text Messages. We may send you voice and text messages through your wireless provider to the number that you have provided us. Messages include appointment reminders, prescription refill messages, general test results and other information. This is a standard-rate messaging program where message and data rates may apply.

Email. We encourage use of our confidential ***Secure Patient Portal*** link on our website as an efficient way to communicate **non-urgent** information (including medication refill requests) between patients and our medical providers. Please contact our staff for more information on registering for our secure patient portal.

Our non-encrypted email address (e.g. info@gtw-health.com) is only for non-urgent, non-confidential matters.

We also encourage use of our confidential ***healow App*** as an efficient way to communicate **non-urgent** information (including medication refill requests) between patients and our medical providers. The healow App is also the platform for the Telemedicine Visit. It provides secure two-way video communication with our medical providers.

Download ***healow App*** to your mobile device. Once downloaded use our unique practice code: HABBAA to find us. Your login is the same as the Secure Patient Portal login.

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☐ **PLEASE READ, INITIAL EACH BOX AND SIGN BELOW.**

☐ **FINANCIAL RESPONSIBILITY.** It is the responsibility of the guarantor on the account to know his/her insurance plan. If you are unsure what your insurance will cover at any given office visit, please contact your insurance company for benefit and payment information prior to your appointment.

- **Adolescent and Young Adult Health and Wellness will file insurance claims to your primary and secondary insurance company.** Your account will reflect the balance after your insurance has paid. We have made prior arrangements with many insurers/health plans to accept assignment of benefits. Depending upon your specific health plan, we may be considered out-of-network.
- **Co-pays, deductibles, outstanding balances and other fees are due and payable at the time of service.** According to your insurance plan, you are responsible for balances not covered/paid by the patient's insurance plan. For patients not filing insurance or for predetermined non-covered services, full payment is due at the time of service unless other arrangements have been made in advance. There are screening tools that are a necessary part of our appointments and are standard of care. The administration and interpretation of these tools must be billed and charged under individual billing codes separate from the office visit. If these services are not covered, you will be responsible for payment.
- **Forms/Letters/Medical Records Review**. This includes school/camp forms, prior authorizations, letters from medical providers, review of medical records, and other paperwork that require staff and medical provider time. Fees will be billed for this service; you will be responsible for the fee. There is not a charge for forms that are completed during a preventative/wellness visit.
- **Outstanding balances.** Any outstanding balances must be paid prior to the office visit or you may be asked to reschedule. If previous arrangements have not been made with our billing office, any account balances over 90 days old will be forwarded to a collection agency.

☐ **ADVANCE BENEFICIARY NOTICE (COVERED VS. NON-COVERED SERVICES).** Health insurers do not necessarily pay for all of your health care costs. Insurance only pays for covered items and services. Coverage varies by diagnosis, service provided, and terms of benefits arranged by individual or employee sponsors of each plan. The fact that insurance may not pay for a particular service does not mean that you should not receive it. If your doctor recommends that you do receive this service, it is always your choice. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. In the event that insurance denies payment for a non-covered diagnosis or a non-covered service, the patient will be responsible for full payment, due upon receipt of a statement from our office. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s) if your health insurance does not include this as a covered item(s) or service(s). We may require a credit card number on file to charge for services deemed not covered by your insurance.

☐ **AUTHORIZATION FOR RELEASE OF INFORMATION TO INSURANCE and ASSIGNMENT OF INSURANCE BENEFITS.** I hereby authorize release of information to my insurance company on file and assignment of insurance benefits to Adolescent and Young Adult Health and Wellness and its medical providers, as this information may be necessary for the completion of my medical claims. I understand I am financially responsible for all charges not covered by my insurance company.

I have read, understand, and agree to this practice's Office Policies, Financial Responsibility, Advanced Beneficiary Notice and Release of Information to Insurance, and Assignment of Insurance Benefits, and I agree that I am the responsible party and am bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I understand that fees not covered by the insurance company, applicable copayments and deductibles, and other fees are my responsibility and are due at time of service. By initialing each section and signing here, I agree that I have read and understand these policies and agree to abide by them.

_____ ✓_____ _____/_____/_____

Name (print) Signature Date

Street Address: _____ Phone Number: _____

City, State, Zip: _____

Insurance Company/Claims Address: _____

Insured Name: _____ Insured DOB: ___/___/___ Member ID: _____ Group ID: _____

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Young Men's HEALTH AND WELLNESS

Patient Name: _____

CONSENT AND CONFIDENTIALITY

By law, we cannot disclose protected health information to parents/guardians of adult patients (ages 18 and above) without specific consent from the patient. Parents/guardians are invited to inform physicians and medical staff of their concerns as appropriate, but please understand our limitations in providing reciprocal information without direct written consent of the patient. We request that all established patients resubmit paperwork, including consent to disclose information to parents, upon turning 18.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for *Adolescent and Young Adult Health and Wellness* and the co-located licensed therapists/dietitians to use and disclose protected health information (PHI) about the patient to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by ***Adolescent and Young Adult Health and Wellness*** describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent. Adolescent and Young Adult Health and Wellness reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the privacy officer for Adolescent and Young Adult Health and Wellness.

With this consent, Adolescent and Young Adult Health and Wellness may:

- ***call or text my phone numbers and leave a message on voice mail or in person*** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results.
- ***mail to my home, e-mail and/or other prior designated alternative address*** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I hereby give my consent for *Adolescent and Young Adult Health and Wellness* to access and use my prescription medication history (which includes but is not limited to prescriptions dating back several years, labs and other health care medication historical information) for treatment purposes. I acknowledge that Adolescent and Young Adult Health and Wellness may use health information exchange systems to electronically transmit, receive, and/or access my prescription history.

I have the right to request that Adolescent and Young Adult Health and Wellness restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Adolescent and Young Adult Health and Wellness to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, in writing, Adolescent and Young Adult Health and Wellness.
may decline to provide treatment to me.

✓_____ _____/_____/_____

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the opportunity to review and request a copy of the Adolescent and Young Adult Health and Wellness Notice of Privacy Practices on the date indicated.

✓_____ _____/_____/_____

Patient Signature Date

AUTHORIZATION AND CONSENT TO TREAT. I grant my permission for treatment at Girls to Women Health and Wellness/Young Men's Health and Wellness by a licensed physician, licensed physician assistant, licensed nurse practitioner, and/or designees, including such personnel as the physician may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. I grant permission for treatment provided according to generally accepted standards of medical practice. This consent will be in effect from this date until cancelled by me in writing.

✓_____ _____/_____/_____

Patient Signature Date

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Young Men's HEALTH AND WELLNESS

ONLY for Adult Patients (18 years of age or older)

Patient Cell Phone Number: _____ Patient DOB ___/____/____

Automated Messages Phone Number: _____ (for appointment reminders, prescription notifications, …)

Other Phone number: _____ ❒ Momcl ❒ Dadcl ❒ Other: _____

Secure Patient Portal Email: _____

RELEASE OF INFORMATION TO PARENT/GUARDIAN

I, _____, authorize Girls to Women Health and Wellness / Young Men's Health and Wellness
Patient Name (print)

to discuss/release the following Protected Health Information and the medical records (including Medical Summary, Immunization Records, Growth Charts, Lab/Radiology Reports and prescriptions) to my parent(s)/guardian, named below, whether in-person, by phone, email or regular mail, as follows:

Please check **ONE** option for release of information.

❑ **Full Release:** Any and all Protected Health Information and the associated medical records pertaining to the medical care I received at or through Girls to Women Health and Wellness / Young Men's Health and Wellness. This may include Information and associated medical records related to Mental Health, Sexual Health, Alcohol/Drugs and HIV/AIDS.

OR

❑ **Partial Release:** Any and all Protected Health Information and the associated medical records pertaining to the medical care I received at or through Girls to Women Health and Wellness / Young Men's Health and Wellness. This may include Information and associated medical records related to Mental Health. Information and associated medical records related to **Sexual Health, Alcohol/Drugs and HIV/AIDS will be EXCLUDED.**

OR

☐ **Specific Release:** Only provide Protected Health Information and associated medical records related to the following **medical condition(s)**: _____.

I authorize this information to be released **to:** _____ **and/or** _____
Print name of parent/guardian **Print name of parent/guardian**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by Girls to Women Health and Wellness, PA / Young Men's Health and Wellness. I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily authorize Girls to Women Health and Wellness, PA / Young Men's Health and Wellness to use or disclose my health information in the manner described above. This authorization expires upon my written request.

_____ _____ _____/_____/_____
Patient Name (print) Patient Signature Date