**1700 N HAMPTON RD STE 105 DESOTO TX 75115 | Phone: (972) 228 6602 | Fax: (972) 228 6619**
www.healthnowpractice.com

Thank you for choosing Health and Allied Health to be of service to you and your family for your healthcare needs. Please read these policies and procedures completely, and if you have any questions, do not hesitate to ask for clarification. We are glad you have chosen us to provide your care. We will make every effort to provide you with quality care and professional support, respect and consideration**.** If you have any concerns, please bring them to our attention immediately.

**(Almost every question can be answered here, so please read thoroughly)**

**Office Hours:** Monday-Friday: 8 AM-5PM (except for holidays)

Saturdays: By appointment 10 AM - 4 PM

Closed: Most Sundays

**Call-In Policy**

To uphold the quality of care and in fairness to all, Providers will not take time out of their daily appointment schedules to accept or return patient's phone calls. Providers will return calls after 5 PM on the same day where necessary.

**Please initial here stating that you understand our policy _____**

**Email and Cell Phone/Texting Policy**

Always be aware that email is not a confidential means of communication. We cannot guarantee that email messages will be received or responded to in a timely and confidential manner. As such, email is not an appropriate way to communicate confidential or urgent information. For reasons of privacy/confidentiality, this office does not conduct treatment through email or texting. It is our policy to meet with the patient

and discuss issues of concern or at least to have a scheduled virtual encounter in accordance with standards approved by the CMS if the patient is unable to come to the office. Patients may use email to schedule, cancel or change appointments. All email messages sent to per request should be followed-up with a telephone call to the office or a voicemail message communicating email per request sent. Health and Allied Health will not communicate by text due to the privacy/confidentiality concerns stated above; and email is certainly NOT a means of contacting the Provider.

**Please initial here stating that you understand our policy _____**

**Telephone Policy**

We take pride in answering your calls in person whenever possible. However, there are times when heavy call volume may prevent us from speaking with you directly. Please leave a clear, short message with your name, phone number and a brief reason for your call on our answering machine. Office staff will contact you as soon as possible regarding your call. If there is an emergency outside of office hours, please call 911 immediately. If you get a recording, please:

- Do not call more than once per day for the same issue.
- Keep your message as brief as possible (name, number and reason for call). For example; “Mary Kay, 992-1212, I need to reschedule my appointment.”
- Allow up to 24 hours for a return call, especially if you call late in the day.
- Medical issues will not be addressed over the phone. Please make an appointment to be seen by the provider ASAP.
- Office Staff will be polite and respectful. They deserve the same in return.
- Calls may be recorded for quality control purposes.

- Abusive or incessant calls are cause for termination. All threats are reported to the relevant law enforcement services.

**Answering Service:** There is NO emergency answering service or on call provider. In the event of an emergency or if urgent care is needed; please proceed to your nearest emergency room or call 911 for assistance.

**Please initial here stating that you understand our policy _____**

**Office Courtesy**

Please consume all food and beverages before coming into our waiting area. Please do not bring babies and/or children to our office unless they are being serviced.

This policy is (1) for their safety and (2) so that you and the clinician will be able to concentrate on your quality care.

Patients under the age of 18 must be accompanied by a parent or legal guardian to each and every appointment. This is required to discuss the minor's condition, issues, progress, and treatment, as well as obtain authorization for treatment plan. If a parent or legal guardian is not present, the appointment will be cancelled and the child will not be seen. When this occurs, a late cancellation fee will be assessed and must be paid before a follow up appointment will be made.

Parents are responsible at all times for their children's behavior in the waiting room, restroom, and office. If a minor's behavior is deemed too disruptive by office staff, they will be asked to leave immediately. Any and all damages to our office will be billed to the parent. The appointment will be cancelled. When this occurs, a late cancellation fee will

be assessed and must be paid before a follow up appointment will be made. No food or drinks are allowed in the office. No smoking. Our office is a non-smoking facility. No pets are allowed in the office, with the exception of service animals. The owner must provide proper documentation for service animal.

**Please initial here stating that you understand our policy: _____**

**Requests for Prescription Refills**

We handle all refills during our regular scheduled appointments. If a medication refill becomes necessary, please provide us with your pharmacy phone number, medication name and how you are currently taking your medication. Note that refill requests may not be honored if follow-up appointments have not been kept. We will require you to make an appointment, and then we will call in enough medication to last until your appointment. **We do not accept fax requests from your pharmacy**. You need to contact us directly for prescriptions refills. **There is a $50 fee for medication refill requests between appointments**. Controlled substances (stimulants, narcotics or benzodiazepines) WILL NOT BE REFILLED until the date the prescription is due to run out.

**Please Initial here stating that you understand our policy_____**

**Confidentiality**

Your medical records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by you, the patient. In an emergency situation when you, the

patient, are at imminent risk of death or serious medical consequence, we will release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. The clinician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of child or geriatric abuse.

**Please Initial here stating that you understand our policy _____**

**Legal Testimony**

Legal matters requiring the testimony of a health professional can arise. This, however, can be damaging to the relationship between a patient and his/her provider. As such, we recommend that you hire an independent forensic health professional for such services. We DO NOT provide court-related and/or disability related health services. If we are subpoenaed to appear in court related matters charges will be per our policy. We gladly provide referral to Forensic experts if requested for any Court Related/Legal/Disability Matter.

**Please Initial here stating that you understand our policy_____**

**Maintaining Patient Status**

In healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, you will be told when to schedule a follow-up appointment. We urge you to make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. If you fail to keep and/or maintain follow-up

appointments for a period of 120 days or greater, we will conclude that you have terminated the patient-provider relationship.

**Please Initial here stating that you understand our policy _____**

**Appointments**

Initial visits are 30-45 mins in duration. After evaluation/examination, recommendations for treatment options are made. Follow-up appointments may be scheduled for 20 and up to 45 minutes, as the case may be. We require that you follow-up and participate in your treatment and recovery. You must follow-up at least every 3 months in order to qualify for continued medication. You may receive a courtesy confirmation call one day prior to any existing appointments. These calls are a courtesy only. You are responsible for your scheduled appointments and will be responsible for any fees incurred from missed or late arrivals, regardless of whether or not your appointment was confirmed.

**Please Initial here stating that you understand our policy_____**

**Payments/Financial Policy**

We accept assignment from most major insurance plans and routinely accept and file claims; However, ensuring that your account is fully paid will be your obligation. Please notify us immediately if your insurance changes so that we may properly file your claims. You will be expected to pay your co-pay/co-insurance for covered services and payment for non-covered services at the time of your visit before you are seen by the provider; if you are unable to pay for your service, you will be asked to reschedule. For your convenience, we accept cash and credit/debit cards (Visa, MasterCard, American

Express and Discover). If a personalized letter is requested, an additional charge of **$25** (total charge) will be applied depending on the extent of the letter needed/requested.

**Insurance-**

Your insurance policy is a contract between you and your insurance company; therefore, we cannot guarantee payment of your claims or accept responsibility of negotiating claims with insurance companies or other persons. In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered. If payment from your insurance carrier is not received within forty-five (45) days, we will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days. Health and Allied Health and its employees do not guarantee that payment will be authorized for services; therefore, this office is not responsible for any adverse payment decisions or misuse of information. Notification of any change in your insurance status (i.e. new company, deductible, co pay amounts) must be provided to the office before your next visit, or payment in full will be required.

**Please Initial here stating that you understand our policy_____**

**Assignment of Benefits**

You hereby assign to Health and Allied Health the right to the insurance benefits that may be payable for the services provided. You understand that acceptance of insurance assignment does not relieve you from any responsibility concerning payment for

services. The doctor may release all or part of my medical record to the insurance company required for processing any claims.

**Please Initial here stating that you understand our policy_____**

**Prior Authorization/Quantity Overrides/Non-Formulary Issues with Insurance Companies Regarding Medications**

Our providers prescribe medication based on your condition/illness. Sometimes your insurance company limits the availability or free access to certain medications. The insurance company may want additional clinical information from the prescribing physician. These types of restrictions are between you and your insurance company.

- Due to increasing demand and the amount of time needed to complete the forms, we will have to charge $25.00 for each medication prior authorization and this amount is due at time of the request.
- Letters of Medically Necessity if a Prior Authorization is denied are $50.00 per letter that may need to be submitted and is due at time of the request. This charge does not guarantee that your insurance will approve coverage of the medication. You will need to contact your insurance company if you are denied coverage of your medication. Please allow applicable processing time for your request. Prior authorizations will be handled in the order they are received and can take up to 10-14 business days to be processed.

**Please initial here stating that you understand our policy_____**

**FMLA Forms/Medical Reports/Correspondence/Disability Forms**

While medical reports to insurance companies and employers are necessary for you to access benefits, they are not medically necessary for your treatment. Therefore, we charge for these additional tasks. Please allow 5 to 7 days for completion of your requests after we have all the appropriate releases and/or information to complete the forms. We must have a signed release from you, the patient, to release information to anyone else. This includes family members, other doctors, insurance companies, and employers. Please make sure you sign our release form at the time of your request. We must have clear instructions as to what method the information will be conveyed to the other party, i.e. fax, mail, telephone. We need complete fax numbers, phone numbers and/or addresses. There is a charge associated with medical records which is as follows: $50.00 for the first 20 pages, and $2.00 per additional page. We require prepayment for these services.

**Please initial here stating that you understand our policy _____**

**We DO NOT Complete Disability Assessment/Determination Forms of Any Type**

**Please initial here stating that you understand our policy _____**

**Controlled Substances**

Controlled Substances (i.e. benzodiazepines, narcotics, and stimulants.) are very useful, but have potential for misuse and addiction; therefore, they are controlled by local, state and federal government regulations. Controlled substances shall not be the first line therapy for any illness or condition. Where necessary, appropriate exceptions and

referrals will be made on a case by case basis, and depending on the illness presentation. Accordingly, we require the patient to agree to non-use of illicit/recreational/experimental drugs. The patient further understands that using illicit/recreational/experimental drugs will impact progress and counter act with prescribed medications; This office reserves the right to drug test the patient where there is reasonable suspicion of mind-altering/psychoactive agents. This testing is not mandatory and you may refuse to have this test done, but the provider may request it at any time for any patient and your cooperation is required. We participate in TPMP, the Texas Prescription Drug Monitoring Program (Electronic-Texas Online Reporting of Controlled Substances). This is a database tool we use to improve patient care by safe prescribing, in addition to reducing drug abuse and diversion.

**Please initial here stating that you understand our policy _____**

**No-Show Policy**

**New Patient No-Shows:**

- In order to schedule again, please leave a credit card number on file with the front desk.
- If patient does not show for the 2nd scheduled new patient appointment they will be charged $25.00 for the appointment.

**Existing Patient No-Shows:**

- After missing one appointment you will be called to reschedule your appointment
- If a 2nd appointment is missed you will be charged a $25.00 no show fee.

- After a 3rd missed appointment the patient will be charged a $50.00 no show fee, and may be terminated.

**Please initial here stating that you understand our policy_____**

**CONSENT FOR TREATMENT WITH PSYCHOACTIVE MEDICATIONS**

Client _____

It is my sole responsibility to ask questions and request more information if I needed with regard to the nature of the disease and all medications that will be prescribed to me during my treatment at Health and Allied Health. If I am not satisfied, I can refuse to accept any treatment including medications without negative actions on the part of staff.

I am also aware that before leaving after each office visit I have the right to ask questions regarding the following:

- The nature of the mental and physical condition being treated for, a description of the proposed course of treatment with medication(s) and the expected beneficial effects on my health as a result of treatment with the medication (s).
- The probable health and mental health consequences of not taking medications, including the occurrence, increase or reoccurrence of symptoms of illness.
- The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefits as the medication(s) and why the physician rejects the alternative treatment.

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- The fact that side effects of varying degrees of severity are a risk of all medications. The relevant side effects of the medication(s) being prescribed including any side effects which are known to frequently occur in most individuals; any side effects to which the individual may be predisposed; and the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time; metabolic side effects such as weight gain and hyperglycemia including development of Diabetes Mellitus. The need to advise staff immediately if any of these side effects occur.

**WOMEN OF CHILD BEARING AGE**

Risks of using these medications in pregnancy including drug interaction which would interfere with the effectiveness of my birth control pill in current/future use, and the need to use alternate birth control measures. If pregnant or breast feeding, I agree to discuss with my obstetrician or pediatrician before starting the medication(s). It is my sole responsibility to receive complete explanation of medication(s) before starting by means of verbal explanation or printed material; and I understand that I may withdraw this consent at any time, refuse to take certain medications and/ or can request for alternative treatment.

**I have read, understand and consent for treatment with psychoactive/psychotropic medications**

Printed Name: _____ Date_____

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You have the right to refuse to sign this Acknowledgement****

Health and Allied Health has provided you a copy of its Notice of Privacy Practices. The Notice of Privacy Practices explains your privacy rights as a patient and includes a complete description of the uses/or disclosures of my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment
- Obtain payment for that treatment; Conduct normal healthcare operations.

The Practice has explained to me that the Notice will be available to me in the future at my request and that I have a right to obtain a copy of the Notice prior to signing this consent. I have been encouraged to read the Notice carefully prior to my signing this consent.

My signature below indicates that I have been provided a copy of the Notice of Privacy Practices by Health and Allied Health. The Practice has given me the opportunity to ask any questions about this notice and all of my questions have been answered.

You acknowledge that you have received or been offered a Notice of Privacy Practices prior to any service being provided to you by Health and Allied Health, and you consent to the use and disclosure of your medical information as set forth herein.

**Please Initial here stating that you understand our policy_____**

**Assignment of Insurance Benefits for Payment from Your Insurance Carrier**

Consent to Release Claims Information and Assignment of Benefits

I hereby assign, transfer and set over to Health and Allied Health all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with the above insurance company (ies) • I hereby consent for Health And Allied Health and its employees or agents to release and disclose any information required about me (or the above named patient) to my insurance carrier, claims administrator, managed care company, or review agency, their employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.

I understand insurance billing is a service provided as a courtesy, and that I am at all times personally responsible for any fees not covered by my insurance carrier. Should any insurance payment be made directly to me or to the insured for monies due on this account, I agree to immediately pay over these funds to Health and Allied Health. I also acknowledge I am responsible for any deductible, co pay, or other balance not covered by my insurance carrier.

I request Payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Health and Allied Health, including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

**Please Initial here stating that you understand our policy_____**

**Informed Consent for Treatment**

This consent applies to a variety of patient situations. Due to practical limitations, alterations are not accepted. If you have any questions regarding this consent form, office management will be happy to assist you.

I. **CONSENT FOR TREATMENT**:

I am presenting myself to Health and Allied Health for evaluation, diagnosis and/or treatment of my medical condition. I give consent and authorize my provider(s) or his designees to perform and/or perform all exams, test, or any other procedure deemed necessary or advisable for the evaluation, diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Health and Allied Health, unless and until revoked by me in writing. I acknowledge that Health and Allied Health is committed to protecting the confidentiality of my medical record information in accordance with applicable laws and regulations. However, in order to provide treatment to me and to conduct billing and other health care operation activities, Health and Allied Health requires permission to disclose my medical records to certain

individuals and entities. Therefore, I give consent and authorize Health and Allied Health to disclose any or all of my medical record information, including but not limited to treatment information, insurance and other financial information and information about communicable diseases such as human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome(AIDS), alcohol and substance abuse, mental health diagnosis and treatment, and laboratory test results("Medical Records"), to the following individuals and entities:

- Physicians and other health care personnel who are involved in providing or managing my health care. Disclosure to these individuals occurs through the sharing of paper medical records and through access to electronic systems, my health insurance plan, Medicaid, Medicare, or any other person or entity that may be responsible for paying or processing payment for my medical treatment;

- Employees, agents, representatives, volunteers or contractors of Health and Allied Health for the purpose of conducting health care activities including but not limited to administration, billing, compliance, quality assurance, risk management, credentialing and any other appropriate health care facility activities or operation**.**

- Any person or entity to which I give written authorization to receive my Medical Records on a form provided by Health and Allied Health or such other forms acceptable to Health and Allied Health.

- Any other person or entity that is required by law to have access to my Medical Records. I understand that the disclosure of my Medical Records may be necessary before my insurer will pay for the cost of my medical treatment. I agree not to hold

Health and Allied Health, its agents or employees liable for any damages as a result of disclosing my Medical

**Records in accordance with this consent.**

## II. ASSIGNMENT OF BENEFITS/CAUSES OF ACTION

In consideration of services rendered or to be rendered to the patient, I assign my transfer of benefits to Health and Allied Health up to the amount of my total financial obligation to Health and Allied Health; all rights, title and interest in benefits payable out of any third-party action, or out of recovery under the uninsured motorist provisions or out of the medical payment provisions of any automobile insurance policy (ies), or out of any other insurance proceeds that I am entitled to recover. I further authorize Health and Allied Health to pursue on my behalf any claim I may be entitled to pursue before the Crimes Victims Compensation Division of the Texas Industrial Accident Board in the event my treatment is necessitated by injuries received as a result of a violent crime, but in no event, shall this be construed to be an obligation of Health and Allied Health. I understand that this agreement in no way restricts me or my dependents' rights to pursue any such claim before the Crimes Compensation Division of the Texas Industrial Accident Board.

## III. FINANCIAL RESPONSIBILITY:

In consideration of services rendered or to be rendered to the patient, I accept financial responsibility and agree to pay for any and all charges and expenses incurred or to be incurred. I further understand that payment is due upon request. Unless Health and

Allied Health has a contract with my insurance carrier that states otherwise**, I am responsible for my remaining balance after reasonable collection efforts have been pursued with my insurance company.** If my account becomes delinquent and it is necessary for my account to be referred to attorneys or collection agencies, I will pay all charges that are my obligation, reasonable attorney's fees and other collection expenses. I have received a copy of the practice policy.

## IV. FEDERAL AND STATE PROGRAMS:

If I am eligible for health care benefits under any federal or state program, including but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs, including Title XVIII and XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to the Social Security Administration or intermediaries or carrier any information needed for any federal or state program related claims, I request that payment of authorized benefits be made to Health and Allied Health on my behalf. I understand that I am responsible for all applicable health insurance deductible and co-insurance amounts under these programs.

## V. ACCIDENTAL EXPOSURE OF HEALTH CARE WORKERS:

I understand that Texas Law provides, and I give consent, that I may be tested for possible exposure to certain communicable disease, including but not limited to the human immunodeficiency virus (HIV), the virus associated with AIDS, hepatitis B and C, and syphilis, such testing will be conducted pursuant to applicable laws and can include

but not limited to the following situation, 1) if a health care worker is exposed to my blood or other bodily fluid.

## VI. PRACTICE POLICIES:

By signing the Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have been offered a copy of the practice policies of Health and Allied Health.

## VII. EFFECT OF CONSENT:

By signing the Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have read and I understand the information contained in this Consent. I accept the terms of this Consent, either on behalf of myself as the patient, or on behalf of the patient as an authorized legal representative of the patient. This Consent supersedes all prior consents or other authorization forms signed by me pertaining to issues discussed herein. I acknowledge that signing the Consent is a condition of treatment by Health and Allied Health and alteration of any/or refusal to sign this form will result in denial of treatment; I understand that I may revoke this consent at any time, except to the extent that Health and Allied Health has initiated actions based on the form. Any revocation of the consent may result in termination of patient care in accordance with the state law.

If signing as the legal representative, I represent to Health and Allied Health that I am the legal representative of the patient. Should my legal authority terminate, I agree to provide written notification to Health and Allied Health.

**Please Initial here stating that you understand our policy_____**

## VIII. REPORTING CHILD OR ADULT ABUSE AND NEGLECT

It is the policy of HEALTH AND ALLIED to adhere to the law set forth in the Texas Family Code for reporting suspected abuse and/or neglect of any child and to the law set forth in the Texas Human Resources Code for reporting suspected abuse and/or neglect of any elderly or disabled individual.

**PROCEDURES**

1. It is the policy of HEALTH AND ALLIED to report any suspected cases of child or adult abuse or neglect. Any employees involved with direct patient care are required by Texas law to report or assist in reporting any suspected cases of child or adult abuse and/or neglect.

2. Reports will be made to the Texas DFPS by calling the Texas Abuse/Neglect Hotline at 1-800-252-5400 or online at www.txabusehotline.org.

3. Physician consent is not mandatory to report suspected abuse/neglect, but every attempt should be made to consult with the physician prior to reporting. If the physician fails to report an incident, the nurse shall report without the PROVIDER's consent.

4. Documentation is a vital part of the medical record. Documentation should include:
   - **a.** Identifying information on patient and significant others;
   - **b.** Identifying information on the alleged perpetrator;
   - **c.** Circumstances surrounding the event, or condition which required reporting;
   - **d.** Relevant background and historical information.

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**5.** HEALTH AND ALLIED employees may be required to provide written and/or verbal court testimony as needed.

**6.** Reports must be filed by affected clinic employees and administrators where any such person, in the scope of their employment, has:
- **a.** Observed an incident that reasonably appears to be physical abuse;
- **b.** Observed a physical injury where the nature of the injury, its location on the body or the repetition of the injury, clearly indicates that physical abuse has occurred;
- **c.** Been told by a patient that he/she has experienced behavior constituting physical abuse.

## General Client Contact Information

**Name _____Date of Birth_____**

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**Address_____**

**City_____ State_____ Zip_____**

**Phone: _____ Phones: Secondary _____**

**Email: _____**

**Pharmacy Name: _____**

**Pharmacy Phone: _____**

**Address_____**

**City_____ State_____ Zip_____**

## Informed Consent for Treatment

**I have read, initialed and understand the general policies and procedures of**

Health and Allied Health.

Printed Name: _____ Date: _____

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Patient Signature: _____ Date: _____

Guardian Signature: Date: _____

Relationship (if other than the patient): _____

**By signing, I acknowledge that I will adhere and agree to all office policies. I am willing to continue with my evaluation or treatment.**

Printed Name: _____

Date: _____

Patient Signature: Date: _____

Guardian Signature: Date: _____

Relationship (if other than the patient): _____