STEWART

Family Medicine & After-Hours

OUR FINANCIAL POLICY

We would like to welcome you to our medical facility; we strive to provide quality care for our patients in a pleasant comfortable atmosphere. If you are covered by health insurance, we will gladly submit the necessary forms to your insurance company. From our experience, we have found that few insurance plans cover the complete cost involved. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating your claims. If you do not have insurance, payment is due at the time of service. If you are claiming a work-related injury, we will file your worker's compensation claim once we have received all necessary information such as carrier name, claim number and date of injury. Also, we must have immediate verification of work-related injury by your employer. If this cannot be verified at time of service, you must pay for your visit (we will not bill you). Note: You must file a report with your employer. Co-payment must be made at the time of service. You will be required to pay your co-insurance payment and any deductible in full. We will also file your secondary insurance with proper information. We accept cash, checks, and credit cards as payment.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits, which are payable to me under the terms of my insurance policy, to be paid directly to the medical facility/provider for services provided. I further authorize the release of any necessary information, including medical information from this office, to my insurance carrier (or in the case of Medicare Part B benefits) to the Social Security Administration and Health Care Financing Administration. I understand and agree that I am financially responsible for charges not paid by my insurance company.

PATIENT RIGHTS & RESPONSIBILITIES

When you are seen by an employee or contractor of the clinic, you have the *RESPONSIBILITY* to:

✶Treat the staff with consideration, respect and dignity✶Understand that your life-style does affect your health✶Take an active part in your health care✶Follow the agreed upon treatment plan. It is your responsibility to inform the provider if you choose not to follow the plan✶Observe facility rules and regulations that are for the safety and consideration of all patients and staff✶Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare✶Report whether you understand a contemplated course of action and what is expected of you✶

When you are seen by an employee or contractor of the clinic, you have the *RIGHT* to:

✶Be treated with respect for the individuals patients comfort, dignity, and privacy✶Be treated equally and receive care without regard to age, sex, religion, race or creed✶Make decision regarding his/her care✶Formulate advance directives and have stuff/practitioners to comply with those directives✶Be free from verbal or physical abuse or harassment from staff✶Receive care that is not determined by patient's ability to pay for services✶Be informed of all costs and expected payment from other resources✶Be informed of his/her rights in advance of care being provided✶Have access to information contained in his/her clinical records within a reasonable time frame✶Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand✶Maintain personal privacy and receive care in a safe setting✶Review your records in the presence of a healthcare professional✶Know the name and qualifications of staff providing your care✶Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand✶Expect that all services, treatment and counseling techniques will take place with your informed consent✶Participate in referral planning✶Have access to the patient comment procedure✶Refuse to participate in research✶Have another individual present in the exam room with you, if you so desire✶

COMMUNICATION VIA TEXT POLICY

Stewart Family Medicine now offers text messaging as a means of communication between the patient and clinic!
Any messages sent by SFM come directly from our office staff and messages received by the patient go directly to the receptionist. Communications between the patient and SFM may contain patient PHI; therefore, we require your signature for approval to communicate with you this way. The messages transmitted between patient and clinic will be archived in a secure portal and will become part of the patient's health record. **It is important to understand that SFM cannot guarantee who will have access to the message that we send**. There is a possibility that the number on file may be incorrect or someone other than the patient may have access to the text message. **Please be sure to confirm your cellular number at EVERY visit.** We hope that this will enhance patient communication to aid in a better patient care outcome.
Please ask our front desk if you have any questions regarding this new policy.

CONFIRM YOUR CELLULAR NUMBER HERE: _____

I HAVE READ AND UNDERSTAND THESE POLICIES OF STEWART FAMILY MEDICINE.

Patient/Guardian Signature		**Printed Name**		**Date**	

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CONSENT FOR TREATMENT

I hereby consent to all medical treatment, procedures, medical treatments, photographs, digital, or other images deemed necessary by the provider. I acknowledge that there is no guarantee as to the results of procedures and medical treatments performed. A copy of this authorization may be used in place of the original. I certify that the information I have provided is true and correct. I am aware that knowingly providing false information regarding my identity, insurance coverage etc. constitutes fraud.

Patient/Guardian Signature		Printed Name		Date	

IF APPLICABLE

MINOR CONSENT FOR TREATMENT

Please list other individuals who are allowed to bring your child to appointments and communicate with regarding appointments, test results and any other medical information related to your child.

NAME	RELATIONSHIP	PHONE NUMBER

I give permission for Stewart Family Medicine to treat my child, _____ (print name), according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating provider.

Patient/Guardian Signature		Printed Name		Date	

IF APPLICABLE

CONSENT FOR TREATMENT *FOR MINOR* *WITHOUT PARENT/GUARDIAN PRESENT*

I, _____ (print name), do hereby consent and authorize Stewart Family Medicine and its providers and staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments.

I give providers and staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for a verbal consent if treatment plan includes vaccines, and the best number to reach me for this is: _____.

Patient/Guardian Signature		Printed Name		Date	

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have either received or been given the opportunity to receive, a copy of a separate document, entitled, "Notice of Privacy Practices" from my medical provider which sets forth this provider's privacy practices and my rights regarding privacy of my protected health information (PHI).
Please contact our front desk if you wish to have a copy.

Patient/Guardian Signature		Printed Name		Date	

STEWART

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BASIC OFFICE POLICIES

CLINIC HOURS

Our clinic is open Monday-Friday 8AM-8PM. Appointments are only scheduled between the hours 8AM-4:30PM. Walk-ins are accepted between 5PM-8PM.

APPOINTMENTS

We see patients from 8AM-4:30PM by appointment only. We do offer "Same Day-Sick" appointments to try to accommodate our established patients for any urgent needs. Please call our office early to check availability. Walk-ins will only be accepted during this time if we have an available appointment on the schedule.

ADDITIONAL FAMILY MEMBERS

You must call the clinic prior to the scheduled appointment if there is the need to add another family member to the existing appointment. There is no guarantee that additional family members will be able to see a provider at the same time.

AFTER HOURS

Our after-hours clinic is open Monday-Friday from 5PM-8PM for urgent care on a walk-in basis only. Please note that we do not provide any chronic or primary care needs or prescription refills during this time. After 8PM, our on call provider can be reached through our answering service should there be an urgent need. For emergencies, please call 911.

CANCELLATIONS/NO SHOWS

Please call 24 hours prior to your appointment if you are unable to be here. This allows us to provide that appointment to another patient. Frequent cancellations less than 24 hours in advance may be marked as "No Show." We reserve the right to only offer same day appointments to patients with more than 2 documented no shows and in some cases this can lead to dismissal from our practice.

CONTROLLED SUBSTANCES

We do not prescribe controlled substances for the treatment of chronic pain or anxiety. You may be referred to a pain management specialist or mental health provider for this. If a controlled substance is prescribed for another reason, urine drug testing will be performed and a controlled substance policy must be signed. These patients also must be seen at least every 3 months.

LAB WORK

We do offer in-house lab services. The labs are drawn in the clinic and are sent out for testing to our contracted laboratory, CPL Labs. It is the patient's responsibility to inform us if labs must be drawn or processed elsewhere for insurance coverage purposes. We do not routinely draw labs that have been ordered by another provider or office. Please talk to the nurse to see if this can be done for you.

TEST RESULTS

If you have any diagnostic testing done (x-ray, labs, ultrasound, etc.) please schedule a follow-up appointment 7-10 days after testing to review results with the provider. Results may not be given over the phone.

PRESCRIPTIONS & REFILLS

Any patient needing a medication refill must give our office a timely notice to process the request. We process these requests within 24-48 hours. We recommend contacting our office 2 weeks before your medication is due for a refill. Please do not wait until you are completely out of your medication. Refills requiring prior authorization from your insurance company can take 5-7 business days. We require checkups every 3-6 months for certain medications in order to monitor the patient's progress and reactions. Please schedule these appointments in advance. Medications will NOT be refilled after hours, no exceptions.

REFERRALS

If we decide to send a patient to see a specialist, a referral must be processed. Referrals take 2-3 business days to process after the provider has seen you. If the specialist that we recommend is not in network with your insurance, it is your responsibility to find another specialist who is. It is also your responsibility to make sure your appointment is scheduled.

DISMISSAL

If you are "dismissed" from the practice, it means you can no longer schedule appointments, get medication refills or consider us to be your primary care provider. Patients are given 30 days to find another provider. During these 30 days, the dismissed patient will only be treated for urgent care needs. Common reasons for dismissal include: failure to keep appointments, non-compliance, abusive to staff, and failure to pay your bill. If you are dismissed from our practice, you will be sent a certified letter to your last known address informing you of our decision. We will forward your medical records to your new provider once a medical record release form is signed and we are notified where to send them.

I HAVE READ AND UNDERSTAND THESE POLICIES OF STEWART FAMILY MEDICINE.

Patient/Guardian Signature		**Printed Name**		**Date**	

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Controlled Substance Policy

We strive to provide the most comprehensive treatment plan for our patients. As such, we are constantly searching for new diagnostic tools that help us meet the needs of our patients. In order for us to be diligent concerning your individual patient care, we are adding a diagnostic tool to our clinical protocol that will allow us to more effectively assess the impact of the medications that are prescribed to you.

We will be administering urine drug screens on a regular basis to <u>all</u> patients who have been prescribed a controlled substance.

The information that we are able to gain from your urinalysis will allow us to analyze drug-to-drug interactions more effectively, which will allow us to treat our patient base more effectively.

AGREEMENT

I authorize the provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

- I agree that I will submit to a blood or urine test when requested by my provider to determine my compliance with my prescribed regimen.
- I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.
- If I lose, misplace my medication or prescription, or if it is stolen, I understand that it will not and cannot be replaced. I will bring all unused medication to every office visit.
- I agree that while being prescribed this controlled substance by a provider at this office, I will not be prescribed this medication by another provider outside of this clinic.
- I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

PATIENT/GUARDIAN SIGNATURE		**PRINTED NAME**		**DATE**	

PROVIDER SIGNATURE		**PRINTED NAME**		**DATE**	

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Authorization of Release of Information to Family Members

DATE	PATIENT'S NAME	DOB

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to release this information to anyone with the patient's consent.

If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will allow this information to be released to those family members listed below.

I authorize Stewart Family Medicine to release my medical and/or billing information to the following individuals:

NAME	DOB	RELATION TO PATIENT
1.		
2.		
3.		

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You may revoke this authorization in writing at any time by notifying your health care provider.

IF AN INDIVIDUAL HAS NOT BEEN LISTED ON THIS FORM-WE CANNOT SPEAK TO THEM ABOUT ANY OF YOUR HEALTH CARE INFORMATION.

If you wish for Stewart Family Medicine to NOT DISCLOSE any of your healthcare information to any individuals, please check the box below and sign the bottom of this form.

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PATIENT'S SIGNATURE		DATE	