Khair Family Practice

Consent Forms

Name: _____

DOB: _____ Act#: _____

Date: _____

Patient Payment Policy

Khair Family Practice strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. These policies apply to all procedures and departments.

Co-Pays: We require payment of co-pays at the time of service, and reserve the right to refuse treatment.

No Insurance: If you have no insurance, we collect the office visit before the visit and the remainder at the checkout. Self pay patients may receive additional bill for services rendered.

Payments: Your insurance company will determine what amount, if any, you owe to Khair Family Practice. Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If there is a balance due to your account, we will mail a detailed statement which is due upon receipt. Do not assume that any statement you receive will be paid by your insurance company. For your convenience, we accept cash, money orders, checks, and Visa, MasterCard, American Express and Discover. If your check is returned for insufficient funds, we reserve the right to add a penalty charge of $25.00 to your account.

Outstanding Account Balances: We may refuse to see patients with an account balance and who are not making regular payments on their account balance. If you have an upaid balance at the end of the billing cycle, we apply a $10.00 late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principal. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance. In the event of an NSF check, there will be a $25.00 NSF charge added to the balance due.

Claim Filing: We happily file your claim with your insurance company as a courtesy. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. Please keep in mind that payment remains your responsibility. We are happy to help aid to get your claims paid, from time to time your insurance company may need you to supply certain information directly. We expect payment in full from you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payment to Khair Family Practice, and we will apply it to your account.

Dependents: You are responsible for payment of services rendered to your dependents on your account. In cases where a written court order allows payment for medical costs associated with a dependent, it is the responsibility of you to obtain reimbursement from the other party involved.

Forms/Letters/Medical Records: In order to complete any forms you require an office visit. The completion of disability forms, FMLA forms, attending physician statements, and other supplemental insurance forms all require office supplies, physician time and staff time to complete. Therefore, a $50.00 fee for each form will be charged and must be pre-paid. Note, there will be a 14 day turnaround time for completion, so make arrangements accordingly. Non-standard or multiple page forms may result in a higher rate. The following procedures are not filed with insurance companies and are subject to prepaid amounts. Sports, college, and school (eye, ear & dental) physicals are a $150.00 prepaid fee. Pre-employment and adoption physicals are a

$150.00 prepaid fee. Any additional labs/procedures that are not included in these services may incur further charges.

Prior Authorizations: Due to high demand and complexity of insurance coverage, prior authorizations may be required for approval of certain medications and/or medical devices. These forms can be very time consuming and require time and labor to complete. There may be a $30.00 charge for completion of prior authorizations.

Out of Office Encounters: Telephone encounters regarding medical advice and/or questions for medical staff are subject to fees based on the discretion of the provider and will be billed to your insurance company accordingly as described above.

Attestation Statement: *By providing my signature, I attest that I have read, understand, and agree to the above Khair Family Practice Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Khair Family Practice to extend credit. I authorize my insurance benefits be paid directly to Khair Family Practice. I authorize Khair Family Practice to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim in compliance with HIPAA regulations.*

Print Name of Patient	Signature of Patient (or responsible party if minor)	Date

Secure Patient Portal and Electronic Medical Record Consent Form

Khair Family Practice offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement: *I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I also hereby consent the clinical staff of Khair Family Practice to view my medication history and medical history from external sources. All of my questions have been answered and I understand and concur with the information provided in the answers.*

Print Patient Name: _____

Patient Signature: _____ Date: _____

No Show Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore it is office policy to charge a $25 no show fee without a 24 hour cancellation notice.

Patient Acknowledgement: *I have read, understand, and agree to the above Khair Family Practice's "No Show Fee Policy."*

Print Patient Name: _____

Signature: _____ Date: _____

Well Visit/Sick Visit Same Day

During the WELL/PHYSICAL visit, the Provider may also discover a condition or illness that requires diagnosis, treatment and/or follow up. Charges for this will be covered as an illness (SICK) visit by insurance, which may require a copay or a CO-INSURANCE or DEDUCTIBLE from you. Determination of any patient responsibility comes from the Insurance Company according to your individual policy benefit.

Patient Acknowledgement: *I have read, understand, and agree to the above Khair Family Practice's "Well Visit/Sick Visit Same Day" policy.*

Print Patient Name: _____

Signature: _____ Date: _____

Khair Family Practice

HIPAA Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA),I have certain rights
to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and professional certifications.

I have received, read, and understand your HIPAA Notice of Privacy Practices containing a more complete and detailed description of the uses and disclosures of my health information. I understand that this office has the right to change its HIPAA Notice of Privacy Practices from time to time as necessitated by changes in HIPAA. I have the right, at any time, to contact this office at the address above to obtain a current copy of their HIPAA Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? YES NO (please circle one)

If so, please list the names below for our record:

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Patient Acknowledgement: *I have read, understand, and agree to the above Khair Family Practice HIPAA Notice of Privacy Practices.*

Patient Name (Print): _____ Relationship to patient: _____

Signature: _____ Date: _____

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement of receipt of the HIPAA Notice of Privacy Practices, but was unable to do so as documented below.

Reason: _____ Staff Initials: _____