Our Family Health

Welcome to our practice!

We are honored to have a great medical providers and care team. We are committed to providing you the best care we can. We know how important it is to have a good relationship with your medical providers and how difficult it can be to select a medical team. Our hope is that we form a partnership to keep you as healthy as possible no matter your current state of health. We will share our medical expertise with you and hope you will take responsibility for working toward the healthy lifestyle that is so important to your well-being.

With multiple medical providers in our clinic, we offer a diverse range of expertise and interest. You are encouraged to select a provider as your Primary Care Provider (PCP) with whom you will schedule the majority of your appointments. That allows you to build a close relationship having a provider that knows you very well.

We make every effort to have your medical team available when you need them. Please call when you are sick for a same day visit and not walk in without an appointment to reduce wait times for everyone. Please keep in mind the provider you see in an urgent visit may not be your usual provider as we rotate same day urgent appointments between providers. We are confident you will receive the same care great care as with your PCP. If you are sick after business hours, you can call our office number to speak to the provider on call.

Convenience is an important part of offering you high quality healthcare. Please schedule your next appointment at the time of check out. The clinic is open Monday through Friday from 8:00 AM until 5:00 PM. The best way to assure you can get an appointment with your PCP is to schedule the appointment in advance.

Please know we respect your time and strive to not have patients waiting for prolonged periods. Although, there are times that medical emergencies will get our staff off schedule, we will try to inform our patients when this occurs. If you wait in the lobby longer than 15 minutes, please bring it to the attention of our staff. Please do not be discouraged if another patient is called back from the lobby before you as there are multiple providers seeing patients daily.

We feel it is important for all patients to have an annual wellness visit to ensure our patients are updated on preventive measures such as labs, immunizations, mammograms, colonoscopies, etc. when appropriate for your age and gender. Many times there is not a charge for these visits; however, sometimes insurance carriers won't pay for certain labs. Please keep in mind if your provider orders it, they feel it is needed. If you have not had a wellness visit in the last year, please schedule one today before you leave.

It gives us great pleasure to be part of your ongoing healthcare, assisting you to reach health goals and keeping you as healthy as possible. It is our hope you will feel completely comfortable discussing your health concerns with us. It is our belief we will succeed as a provider-patient team if we are honest with each other, respect each other and remember we are a team.

We ask you let us know if you are ever dissatisfied with the care you receive so we can work to assure you receive the highest possible care. Let's work together to help you live the satisfying life you deserve and thank you for allowing us the pleasure of serving as your healthcare team.

Our Family Health's Management Team

Our Family Health

Abuse Policy

Our Family Health (OFH) is pleased to accept patients who accept our services. We do not discriminate on the basis of sex, race, national origin, ethnicity or religious affiliation.

Please know we respect your need for a safe, friendly and caring environment to receive care. OFH will take the necessary steps to ensure all patients and visitors to our practice are shielded from experiencing any abusive or offensive behavior or treatment while with us. We expect all providers, staff, patients and other visitors to behave in a civil, courteous, respectful manner.

Patients who are not compatible with our providers, our staff or our mission, may be asked to obtain healthcare elsewhere.

The following behaviors are considered incompatible with our practice:

- Abuse of our equipment, facility or supplies
- Abuse of patient portal access making excessive requests
- Contacting providers directly on their personal cell phone to request refills, medical care or recommendations
- Contacting providers directly via social media to request refills, medical care or recommendations
- Disrespect for the needs of other patients visiting our practice
- Making derogatory remarks about OFH regarding any issue verbally to others or on social media without informing OFH Management prior to address or correct the issue
- Making false statements about OFH on social media
- Repeatedly missing scheduled appointments
- Threatening behavior of any kind toward providers, staff, patients or clinic visitors
- Unwilling to follow medical recommendations or treatment plans
- Unwilling to schedule recommended follow-up appointments or tests as prescribed by our providers
- Wandering the clinical areas unescorted or otherwise violating patients' privacy rights as per HIPAA guidelines

Anyone who demonstrates the behaviors outlined above will be asked to take corrective action before returning to our office. Continued incompatible behavior may result in the termination of care.

While the great majority of our patients and patient families do not fall into any of these categories, we are required to advise all patients and patient families of our policy and not single out any one person.

Thank you for your compassion and cooperation. 10.23

Financial Policies

07.23

Welcome and Thank You for choosing Our Family Health (OFH) for your medical care. We are committed to providing you with the highest quality medical care possible in a cost-effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill. Payment in full is due at the time of service. OFH accepts cash, money orders, personal checks, American Express, Discover, Mastercard and Visa.

We also provide our patients the ability to access their account statement and make payments through our secure patient portal at https://health.eclinicalworks.com/OFHC.

In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policies.

Please inform the staff member that schedules your appointment and/or the receptionist of any demographic changes such as phone number, address, insurance information, etc.

Things to bring with you to EVERY appointment

- Driver's License
- Health insurance card(s)
- Your choice of payment

Payment Due at Time of Service

- Co-pays and co-insurance amounts, deductibles and all non-covered items and charges are the insured's/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in may result in your appointment being rescheduled. Your copay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.
- If you receive more than one type of service on the same day, your insurance may hold you responsible for more than one co-pay.
- We strive to be as accurate as possible in calculating your responsibility; however, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office after your insurance carrier has processed your claim.
- Failure to pay balances may result in discharge from the practice with the balance sent to a collection agency.

Accepted Forms of Payment

- Cash
- Checks
- Credit/Debit Cards: American Express, Discover, Mastercard and Visa

Self-pay Patients

- We offer a reasonable discount for our cash paying patients. We will give you an estimate of what will be due for services and payment is due at the time of service.
- You will be asked to sign a waiver stating that you have no health insurance and will not be filing with any health insurance carriers. Failure to sign this waiver may result in cancellation of your appointment.

Workers' Compensation

- OFH will bill workers' compensation claims on your behalf as a courtesy if provided the required information to include name, address, phone number, and fax number of the worker's compensation insurance company where the claim is to be sent, name and phone number of the worker's compensation case manager, worker's compensation claim number, and date the injury occurred.
- If the claim is denied, you will be responsible for the balance within 30 days from your first billing statement date.

Insurance

- It is your responsibility to know your insurance benefits.
- It is your responsibility to know if your chosen provider is contracted with your insurance.
- It is your responsibility to obtain all necessary insurance required referrals BEFORE your appointment.
- As a courtesy to our patients, we will file your insurance claim for you. However, the balance on your account is your responsibility if insurance does not pay.
- It is your responsibility to provide OFH the correct insurance information for every visit. If we do not have your current insurance policy information on the day of your visit, you are responsible for providing us the correct information within 30 days of your date of service. If that information is not received, we will be unable to bill the insurance company and you will be responsible for the balance.
- It is your responsibility to communicate issues to your insurance. Insurance companies will not communicate with third parties regarding your benefits.
- If you acquire insurance after a visit that was retroactive to the time of that visit, it is your responsibility to communicate all necessary information in order to submit a claim for OFH to be paid. You may be reimbursed after payment is received from the insurance carrier. There will be no submission of claims greater than 30 days after date of service.
- Your estimated portion due for each visit is due on the date of service. Your insurance carrier may leave an additional balance due by you after the claim is processed, which will be your responsibility to pay.

In Network vs Out of Network Insurance

- Your insurance coverage and benefits are a contract between you and your insurance company; therefore, all disputes must be handled between you and your insurance company.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a self-pay patient.

Auto Accident or Liability Injury

- If your visit today is due to an auto accident or injury as a result of another party's negligence, you are required to pay for services upfront.
- OFH will not file the insurance claim for you but will provide you with a receipt to do so yourself.

Billing

- If you receive a bill from us, it is because your insurance carrier has allocated the balance to be your responsibility. Please contact your insurance company if you think there is a problem with what they have or haven't paid.
- Any amount not covered by your insurance is due within 30 days of receipt of your OFH bill. •

If you cannot pay your entire balance, please call our office to discuss payment arrangements.

Returned Checks

- There will be a $35 charge to you for any check returned by your bank for any reason, which is not billable to your insurance and will be your responsibility.
- Future payments may be required to be made by cash, credit/debit card or money order.

No Show Fees (See Patient No Show Fee Policy for full details)

- $35 – Office visit appointments
- $50 – Office visit appointments extended
- $50 – Mammography appointments
- $50 – Allergy, massage, and non-vein ultrasound or echo imaging appointments
- $200 – Vein mapping appointments

Refunds

- Refunds are issued to the party that made the overpayment.
- Patient refunds will not be processed until all active or past due charges are paid in full.
- Refunds may take up to ten business days to process once requested.

Collections and Outstanding Balances

- Any outstanding balance without payment after 90 days of the first statement sent may be sent to an outside collection agency. Accounts referred to an outside collection agency will receive a collection fee of 35% that will be added to the total balance due. That balance must then be paid to the collection agency.
- Patients with unpaid accounts sent to a collection agency may be discharged from our practice.

Our Family Health

PATIENT REGISTRATION

Patient Name: ______________________________________ DOB: _____________ Sex: _____ Age: _____

Social Security Number: _______________________________ Marital Status: _______________________

Mailing Address: ____

City: _______________________________________ State: _________________ Zip: ________________

Email Address: ____

I would like access to Patient Portal _____ Yes _____ No

I understand that by not using the Patient Portal, I will still need to schedule follow up appointments to receive all test results.

Telephone: Home: ____________________ Cell: _____________________ Work: _____________________

I would like to receive text reminders for appointments _____ Yes _____ No

Preferred Language: __________________________ Ethnicity: _________________ Race: ____________

Responsible Party (if other than Patient): ____

Referring Physician: __________________________ Primary Care Physician: ________________________

Emergency Contact: _________________________ Relationship: _____________ Phone: ______________

Primary Insurance: ________________________________ Policy Holder Name: ______________________

Member ID: _______________________________________ Group Number: _________________________

Secondary Insurance: ________________________________ Policy Holder Name: ___________________

Member ID: _______________________________________ Group Number: _________________________

Please be sure to provide any tertiary insurance information to the front desk staff as well.

Preferred Pharmacy: ____

Mailing Address: ____

Phone: ____ Fax: ______________________________________

***** Please present your Photo Id and Insurance Card upon arrival at Every Visit ***** 10.23

HIPAA Consent for Use and Disclosure of Health Information

Patient's Name: ____ Date of Birth: _______________________

I understand that my health information is Private and Confidential. I understand that Our Family Health (OFH) works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that OFH may use and disclose my personal health information to provide health care to me, to handle billing and payment, and take care of the other health care operations. In general, there will be no other uses or disclosures of this information unless I authorized it in writing. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

OFH has a Notice of Privacy Practices which contains detailed information about the policies and practices protecting my privacy. By signing this agreement, I am stating that I have read and received a copy of the Notice of Privacy Practices. I understand that OFH may update the Notice of Privacy Practices as they deem necessary, and I may request to receive a copy of the most current version at any time.

Please list anyone whom we may release medical information to along with their Relation/Contact #'s

Name: _________________________________ Relationship: _____________ Contact #: __________________
Name: _________________________________ Relationship: _____________ Contact #: __________________
Name: _________________________________ Relationship: _____________ Contact #: __________________
Name: _________________________________ Relationship: _____________ Contact #: __________________

Our Family Health is a part of CommonWell, EPIC, Prisma, and other EMR type users. What this means is that we can access your records from Hospitals, Specialist and other medical professionals participating in your healthcare. We also can contribute our records for your Specialist to see. This is very important so that all doctors participating in your care have all needed medical knowledge to supply you the best possible care. If you do not approve of us accessing your medical records or making your records accessible only to medical providers caring for you then please check the box below that you would like to opt out of the medical record interfacing systems.

☐ By Checking this box, I understand that None of my medical information will be released to the above.

If you have a Medical or Financial Power of Attorney and/or Caregiver, please list their information.

Medical POA: ___________________________________ Contact #: ___________________________ Financial POA: ___________________________________ Contact #: ___________________________ Caregiver: ___________________________________ Contact #: ___________________________

Under the terms of this consent, I can ask OFH to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care options. I understand that OFH does not have to agree to my request. If OFH does agree to my request, I understand they will follow those agreed limits.

I may update my consent by completing a new HIPAA Consent for Use and Disclosure of Health Information or I may cancel this consent in writing at any time by writing, signing and dating a letter to OFH. The letter must say that I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment, and health care operations. If I revoke this consent, OFH does not have to provide any further health care services.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: The OFH Compliance Line via the following methods:
Compliance Hotline at **1(770) 829-0164** or **Compliance EMAIL:** **Compliance@ourfamilyhealthcenter.com**

This notice is effective as of April 3, 2023. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

My signature below means I agree to allow OFH to use and disclose my personal health information to carry out treatment, payments, and healthcare operations.

_______________________________________ _______________________________

Patient or Legal Authorized Individual Signature Printed Name

_______________________________________ _______________________________

Relationship to Patient Date

MediCopy Authorization for the Release of Medical Records

Where are the records being released from? Telephone / Fax Numbers:

Facility Name: Provider Name(s):

Address: City: State:

Tell us about the patient.

Name: DOB: SSN: XXX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released? Check all that apply.

- ☐ All Records
- ☐ Office/Clinic Notes
- ☐ Operative Reports
- ☐ Psychological/Psychiatric, if any
- ☐ Lab/Pathology Results
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ Substance Abuse, if any
- ☐ Last Two Years of Records
- ☐ Dates ______________________________ to ______________________________
- ☐ Other____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

- ☐ Substance Abuse, if any
- ☐ AIDS/HIV/STDs, if any
- ☐ Psychological/Psychiatric conditions, if any

Purpose of Disclosure: Why are we sending the records?

- ☐ Personal Use
- ☐ Litigation/Legal
- ☐ Insurance
- ☐ Continuation of Care
- ☐ Transfer to New Physician

Delivery Method: How would you like the records sent?

- ☐ Email
- ☐ Fax
- ☐ Postage (additional fee applies)

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: Date:

Relationship to patient:

Our Family Health

Patient No Show Fee Policy

A No Show Fee is charged when a patient doesn't show up for a scheduled appointment and doesn't give Our Family Health (OFH) the correct notice stipulated below that the appointment needs to be cancelled or rescheduled. If and when this occurs, OFH will charge a No-Show Fee that is not covered by insurance and will be patient responsibility.

All patients are given a 15-minute grace period for their scheduled appointment. Any patient running late should call the office to notify a staff member what time they expect to arrive. If the delayed time will not conflict with other scheduled patients or the provider's schedule, patients will be advised to continue their trip here to be fit in; however, the appointment may be rescheduled.

OFH Management will evaluate if patients arriving later than 15 minutes from their scheduled time are able to be worked in. There is no guarantee that the patient will see the provider they were originally scheduled with nor if they will be seen that same day. Please know that OFH will do our best to see all patients when possible. All appointments for controlled substances must be rescheduled as patients must see the prescribing provider for those medicines.

No Show Fee Schedule

- $35 Office Visits = 24-hour Notice Required
  (Fees for urgent/same day appointments are applicable and will be reviewed by management)
- $50 Office Visits Extended = 24-hour Notice Required
  (Extended Visits to Include: New Patient, Annual/Wellness Visits, DOT Physicals, Procedures/Joint Injections)
- $50 Allergy = 48-hour Notice Required
- $50 Mammography appointments = 48-hour Notice Required
- $50 Massage = 48-hour Notice Required
- $50 Non-Vein Ultrasound or Echo Imaging, Holter Monitor, and Sleep Study, and Dexa Bone Density Scans = 48-hour Notice Required
- $200 Vein appointments = 48-hour Notice Required

All No-Show Fees must be paid in Full prior to any further service. Calling the OFH Answering Service or sending a Patient Portal message <u>are</u> acceptable forms of timely cancellation. Three no-shows within 365 days and/or 6 cancellations within 365 days are grounds for dismissal.

I acknowledge I have read and understand OFH's No Show Policy and agree to fees associated with this policy if I fail to comply.

____ __________________________

Patient/Guarantor Signature Date

1016 E Spring Street ▪ Monroe, GA 30655-2469
☎ 770.464.0280 ▪ www.ourfamilyhealthcenter.com ▪ 770.464.0233

Our Family Health

Patient Name: ____ **Date of Birth:** _________________

Acknowledgement

I acknowledge that I have been given a copy and read Our Family Health (OFH) **Abuse Policy**. I have been given the opportunity to ask any questions and/or receive any needed clarification of these policies.

I acknowledge that I have read and completed the **HIPAA Consent for Use and Disclosure of Health Information**. I have also been given the opportunity to ask any questions and/or receive any needed clarifications of this policy.

I have read and understand the **Financial Policies** to include the **Patient No Show Fee Policy** and agree to abide by their guidelines. Furthermore, I have received a copy of the OFH's Financial Policies. I acknowledge that if I had any, my questions have been answered with explanations given for any needed clarification.

I acknowledge that I have read a copy of OFH's **Notice of Privacy Practices**. I am also aware that I have been given the opportunity to ask any questions and/or receive any needed clarification of these policies and can obtain a copy of the notice whenever I request.

Treatment Authorization: I authorize OFH to give me reasonable and proper medical care which the medical doctor deems is in my best medical interest.

By signing below, I acknowledge that I have been provided a copy of Our Family Health's policies outlined above to read, review and get clarification. I acknowledge that I have been given an opportunity to ask questions and clearly understand the above policies. I also understand that I can receive a printed copy today or at any time by asking the staff of OFH or I may review it via my secured patient portal or the OFH website.

_______________________________________ _______________________________

Patient/Guardian Signature Date