Tricounty Center for Integrative Medicine

4800 Linton Blvd. Suite D-502A, Delray Beach, Florida 33445
Phone: 561.808.7205 brainfixmd.com Fax 561.584.6804

POLICIES & PATIENT AGREEMENT

(Please initial each section)

_____ Appointments: Due to the sensitive nature of matters discussed and in order for us to give our full attention to the person being evaluated, children may not come to the appointment, unless he/she is the one being evaluated. For patients under the age of 18, all persons with legal, medical decision making authority should be present for the initial evaluation. (It is important that all legal guardians sign the consent for treatment.) In order to give you and our other patients the highest level of care possible, if you are more than 15 minutes late and/or you haven't completed your paperwork it may be necessary to reschedule your appointment and you may incur a reschedule fee.

_____ General information on prescription refills: Typically, your provider writes prescriptions for the amount of medication needed until your next scheduled appointment, a 30 day supply at a time. Every time you have a medication management visit, she may send your prescriptions directly to your pharmacy electronically if desired. In some cases, a hard copy prescription is required and this will be given to you at your appointment.

_____ Medication Extensions: If you are an existing patient and will be out of medication we've previously prescribed (before you can get in for an appointment), we can extend that prescription for you as long as you have the next appointment scheduled. Medications refill requests called in to the office **may take up to 72 hours to fulfill.**

_____ 90-day Supplies: Our clinic receives requests from our patients for a 90-day supply of their medications or to have their prescriptions sent to a mail order pharmacy. When feasible we are happy to do this. In most cases, the mail order groups will only fill a prescription for 90 days at a time. Unfortunately, each request for a 90-day supply of medication must be reviewed and discussed as this can increase risks for some patients and at times this may not be possible with some medications.

_____ Cell Phones & Messages: It is important to note that cell phones may not be secure. If you are using a cell phone while communication with our office, you must be aware that we cannot ensure the confidentiality of the call. It may be necessary at times for our office to leave you a message at the phone numbers you provide us. By suppling us with specific phone numbers, you authorize us to leave messages for you at those numbers.

_____ Emergency Access: We try to service our clients whenever possible; however we are not a 24 hour facility. In case of an emergency call 911 or go to the nearest emergency room. Urgent matters that can be managed within 72 hours, please leave a message and an office staff member will contact you on the next business day.

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_____ Missed, late, cancelled and "no show" appointments: As scheduled appointment times are reserved especially for you**, all appointments are subject to charge**, whether forgotten, no show, or canceled at time of visit. **To avoid being charged THE FULL AMOUNT for a missed appointment**, you must provide at least 24-hour notice. It is our policy that time lost, not the reason, is what determines a charge.

In the event you "no show" an appointment, your account will be charged a "no show" fee of **$50.00 for the first offense**. At the second offense (no show, unattended or SAME DAY CANCELLATION), your account will be **charged for the full amount** of the appointment. This may exclude bonafide emergencies.
The office is open Monday – Friday from 11 AM to 5 PM and by appointment as needed.

_____ Limits of Confidentiality Statement: All information between practitioner and patient is held strictly confidential. There are legal exceptions to this: (1) the patient authorizes a release of information with a signature. (2) The patient's mental condition becomes an issue in a lawsuit. (3) The patient presents as a physical danger to self or others. (4) Child or Elder Abuse and/or neglect is suspected. (5) Any official review of the services provided (if you have signed a release authorizing a review, such as insurance forms). In the case of (3) or (4) above, our clinic is required by law to inform potential victims and legal authorities so that protective measures can be taken.

_____ Consent for Treatment: I authorize and request my practitioner to carry out exams, treatment, and/or diagnostic procedures, which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment.

_____ Photo Authorization: I give authorization to Dr. Heidi Erickson and NP Jackson and their affiliates to obtain a photograph of me for my permanent medical records. I understand that the photograph is to help my providers provide proper patient identification and will not be copied or released. For patients under 18, a parent will be asked to be in the photograph as well.

_____ HIPPA Privacy Practice Notice: I understand Dr. Heidi Erickson and NP Jackson follows HIPPA privacy guidelines which are outlined in their NOTCIE OF PRIVACY PRACTICES, which is available at their office.

_____ Release of Confidential Information to Primary Care Physicians and/or Referring Practitioners: It is a requirement of many insurance companies, as well as an acceptable protocol under HIPPA Guidelines, that we communicate and coordinate with other healthcare professionals involved in your care. By signing below, I authorize the release of information to my Primary Care Physician, other healthcare providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I

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further authorize the release of information for claims, certification, case management, quality improvements, benefit administration and any other purposes related to my health plan. I authorize the release of necessary information to a collection agency should that become necessary.

_____Telephone calls to discuss care and provide any service other than medication refill will be billed at the rate of $50.00 for 5-10 minutes, $150.00 for 11-20 minutes and $175.00 for 21-30 minutes as this represents time spent in consultation. These charges will be deferred to the next in office visit when they will be collected.

_____ Payment responsibility: I understand that I am responsible for all fees charged at the time of visit (even if you have private insurance. If your insurance does pay, then you will be promptly issued a refund of the cash discounted rate). I agree to pay for all services rendered at the time of each visit. Your bill may be turned over to a collection agency if your account becomes delinquent and you will be responsible for payment of all legal and all other collections costs. There will be a $35.00 service charge applied to your account for all returned checks.

_____ Relationship: I understand that medical providers at Tricounty Center for Integrative Medicine acting in the capacity of a consulting provider while they may provide requested opinions about optimizing health and treating specific conditions, Tricounty Center for Integrative Medicine does not seek to assume the role as your primary care provider. Rather, we will work in conjunction with your selected primary care provider to help optimize your health. Again, Tricounty Center for Integrative Medicine providers provide consultative not primary care services.

By signing below, I certify that I have read and understand these polices and agreements and have full knowledge of is meaning an effect.

X_____ _____

Patient or Parent/Guardian Signature Date

_____

Patient Printed Name