



## **COMPREHENSIVE PATIENT AGREEMENT FORM**

As your providers, we are committed to providing you, the patient, with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our practice policy and procedures that effect all providers and patients.

### **OFFICE HOURS:**

**8:00am-5:00pm Monday through Friday.**

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment by phone or the online patient portal. **Missed appointments and/or last-minute cancellations may incur a \$25 charge.** You may call our office at (941) 375-3006 for any appointment change notifications.

### **PRESCRIPTIONS AND REFILLS:**

You are responsible for your medication and their refills. Please call the pharmacy for all refill requests. The office has a 24 hour and a 48 hour turnaround policy regarding digital and written prescriptions accordingly. The pharmacy will notify our office of your request. ***This process is much faster as we will have all the information that the pharmacy needs to process your refill.*** In order to comply with the Drug Enforcement Agency there will be NO prescriptions called in after hours or on weekends by any on-call Provider. Controlled medications will not be "called in" under any circumstances.

### **AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS**

We strongly feel that all patients deserve from us the best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. *Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.* Please read the following:

- I authorize Restore Medical Partners to release or receive any information necessary to expedite insurance claims.
- I hereby authorize Restore Medical Partners to bill my insurance company directly for their services.
- I authorize payment directly to my Physician of any insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree and endorse any payment I receive over to my Physician for which these fees are payable.

I understand that I am directly and fully financially responsible to my Physician for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay by balance in full, or there is no payment made within 60 days, it is my responsibility to pay my bill directly. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee. I have read and understand what is expected of me, the patient, in relation to any care, my insurance carriers and my financial responsibilities.

### **PAYMENT AT THE TIME OF SERVICE**

It is our office policy that payments are due at the time of service. If we have a contract with your insurance company, we will file with your insurance on your behalf. However, YOU are responsible for all co-pays, co-insurances,



deductibles, and or non-covered services at the time of service. It is also your responsibility to make sure you have a valid referral and or authorization on file with your insurance company for dates of service billed on your behalf. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the information provided to the office is the most recent insurance information and it is true and correct to the best of my knowledge. I will notify the office of any changes in this information. A photo copy or other reproduction of this will be as valid as original. I hereby authorize Restore Medical Partners to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents, all information with regard to my medical care. I also consent to receive medical care from Restore Medical Partners.

### **Online Communication HIPAA**

Upon signing the HIPAA consent form, you agree to be solely responsible for your username and password. It is not to be shared. If you choose to share this information you are allowing that person to see your PHI (Private Health Information). By signing this form you acknowledge and accept all of the following:

- I have been explained the details of the online patient portal. I understand them, and my questions have been answered.
- Alternative methods are available to me via (in person, mail, telephone).
- I am aware that my private health information (PHI) carries a risk to my privacy should it be compromised.
- I agree to take precautions to keep my online communication safe, including but not limited to:
  - Keeping passwords confidential.
  - Closing my computer or screen when not in use.
  - Refraining from storing PHI on employer-owned computers or phones, etc.

I agree to indemnify and hold harmless, Restore Medical Partners, of and from any claims, losses, causes of action, damage, lawsuits, judgements, including attorney's fee and cost.

### **HIPAA Notice of Privacy Practices**

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.**

RESTORE MEDICAL PARTNERS adheres strictly to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at all times. The following method of operations will be used to insure privacy of a patient's Protected Health Information (PHI).

- Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without you or your legal designee's signed authorization.
- You may review your records by scheduling a time with the office.
- After review of your records if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart.
- If an appointment with another medical provider is required, only the necessary information to schedule an appointment will be provided.
- If you elect to not allow any other member of your family access to your records you have the right to notify our office. That notice must be in writing. If you wish to provide access to your records to a designated individual you may also provide that notice in writing.
- Our office will not provide any information about you or your medical condition to any other party other than other medical providers to whom you have been referred for treatment without your specific authorization.
- If you are chosen to be part of any research program you will be required to sign additional authorizations and releases so that your PHI may be used in the program.



- Under the HIPAA rules, we may use the necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignment allows the practice to file insurance on your behalf.
- There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI.
- We are required by law to protect and privacy of all of our patients, preventing any and all disclosure of PHI to unauthorized parties.
- We are required by law to maintain the privacy of, and to provide individuals with, this notice of our legal duties and privacy practices with regard to PHI.
- If you are on active duty military or are called to active duty military, under federal law we are required to supply a copy of your record.

### **Patient Rights**

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

### **Late cancellation/ "No Call, No Show" Policy**

Restore Medical Partners is committed to providing high quality, efficient, and timely care to all of our patients. If an appointment is canceled or rescheduled within 24 hours of your scheduled time, a \$25 fee may be applied. There will also be a \$25 charge for all "No call, No Show" appointments. Please make note of the person's name that you spoke with when cancelling or rescheduling your appointment. We understand that there may be extenuating circumstances that cannot be controlled, so we will do our best to accommodate.

Thank you for your cooperation and understanding.

I hereby acknowledge receipt, understanding, and agreement with all information listed within this Comprehensive Patient Agreement. I also acknowledge that these policies have been put in place for the benefit of patients, including myself, and that I commit to abiding by these guidelines whilst I am a patient of Restore Medical Partners.

PATIENT SIGNATURE		DATE	
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## CONTROLLED MEDICATION TREATMENT AGREEMENT

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort. A record of all prescriptions and treatments will be maintained by the office as well as your updated treatment plan.

SHOULD I BE PRESCRIBED AND AGREE TO BE TREATED WITH CONTROLLED MEDICATIONS: I the patient understand I will need to remain compliant to remain a patient of Restore Medical Partners and that I have the following responsibilities: **A.** I will take medications only at the dose and frequency prescribed. **B.** I will not increase or change medications without the approval of this doctor. **C.** I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities). **D.** I will not request opioids or any other pain medicine from physicians outside of Restore Medical Partners. My doctor will approve or prescribe all other mind and mood-altering drugs. **E.** I will inform this doctor of all other medications that I am taking. **F.** I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement. **G.** I will protect my prescriptions and medications. Lost prescription or medication will not be replaced. I will keep all medications from children. **H.** I agree to participate in psychiatric or psychological assessments, if necessary. **I.** If I have an addiction problem I will be forthright with the doctor, **J.** I will not use illegal drugs or alcohol. **K.** If a new condition develops, such as trauma or surgery, then the physician treating that problem may prescribe narcotics; however, I agree to notify Restore Medical Partners within 48 hours of such a prescription.

1. This doctor may ask me to follow through with a program to address actual or suspected addiction issue. Such programs may include the following: 12-step program and securing a sponsor, Individual counseling, Inpatient or outpatient treatment or other treatment.
2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking. I also consent to random pill counts, and agree to report within 24 hours when requested.
4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
5. I understand that this doctor may stop prescribing opioids or change the treatment plan if: **A.** I do not show any improvement in pain from opioids or my physical activity has not improved. **B.** My behavior is inconsistent with the responsibilities outlined in #1 above. **C.** I give, sell or misuse the opioid medications. **D.** I develop rapid tolerance or loss of improvement from the treatment. **E.** I obtain opioids from other than this doctor. **F.** I refuse to cooperate immediately when asked to get a drug screen. **G.** If an addiction problem is identified as a result of prescribed treatment or any other addictive substance. **H.** If I am unable to keep follow-up appointments.

**YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS/ ANELGESICS/ BENZODIAZEPINES:** You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving. **SIDE EFFECTS OF OPIOIDS:** • Confusion or other change in thinking abilities • Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles • Breathing too slowly – overdose can stop your breathing and lead to death • Nausea • Sleepiness or drowsiness • Vomiting • Constipation • Aggravation of depression • Dry mouth **THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.** **RISKS:** • Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following: Runny nose Difficulty sleeping for several days Diarrhea Abdominal cramping Sweating 'Goose bumps' Rapid heart rate Nervousness • Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it. • Tolerance. This means you may need more and more drug to get the same effect. • Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors. • Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician. **PAYMENT OF MEDICATIONS:** State law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. You and your doctor should discuss other sources of payment for opioids when L&I can no longer pay.

I have read this document, understand, and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

PATIENT SIGNATURE		DATE	
PHYSICIAN SIGNATURE		DATE	

