Community Healthcare Partners NE
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# Consent to Treat and Financial Policy

**Consent for Medical Treatment** I, the patient or the authorized representative of the patient, hereby consent to any examination, evaluation and treatment provided for any illness, injury, or other health concern affecting me at any time I present at Community Healthcare Partners for medical care. These services may include but are not limited to: laboratory procedures, x-ray examinations, review of external pharmacy information and medical and/or surgical treatment or procedures.

**Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications.** If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

### Uses/Disclosure of PHI for Electronic Health Information Exchanges

Community Healthcare Partners (CHP) may access and disclose PHI through approved Health Information Exchanges (HIEs). Members of the Workforce may not access their own medical records via the HIE. Use and disclosure of PHI is restricted to the permitted uses and disclosures of the particular HIE. The Enterprise Applications Executive Director authorizes individual access to the HIE. CHP is a member of the following HIEs:

CyncHealth (Previously NeHII)

CyncHealth participants may access CyncHealth PHI pursuant to CyncHealth's Privacy and Information Security Policies and Procedures. If unsure as to whether a particular use or disclosure is permissible, contact the Privacy Office.

eClinicalWorks/eCW integrated HIE Software

eCW-integrated HIE Software, includes but is not limited to Carequality and Commonwell Health Alliance. Use or disclosure of PHI available eCW-integrated software is generally restricted to treatment purposes only per eClinicalWorks current Rules of the Road agreement. It generally may not be used for payment, health care operations or any other purposes, regardless if otherwise permitted under HIPAA.

eHealth Exchange

1. Includes federal and non-federal organizations. Veterans Administration (VA) is a participant of this HIE. Members that access this HIE, as such, PHI obtained via the eHealth Exchange generally may only be used or disclosed for treatment purposes.
2. All users of the eHealth Exchange are required to cooperate with CHP on related investigations or issues; request, use and disclose eHealth Exchange message content only for treatment purposes; comply with all applicable laws and report any suspected breach of PHI to the Privacy Office immediately. Users must not disclose passwords or any other security measures to anyone.

**Financial Policy**

1. All patients must provide accurate and complete personal and insurance information prior to being seen by the physician, physician assistant, nurse practitioner or other medical care provider/practitioner.
2. CHP will file a claim with your insurance company; however, it is your responsibility to comply with all predetermination, pre-authorization and/ or notification requirements as may be required by your insurance plan. While many of the services provided by CHP may be covered benefits of your insurance plan, how these benefits are paid by your insurance provider and/or whether or not certain services are considered to be non-covered services is determined strictly by your insurance provider and not by our office. It is your responsibility to understand the limitations and exclusions of your insurance plan, as well as to understand your co-pays, deductibles, in-network and out of network coverage including any and all applicable limitations, inclusions and/or exclusions.
3. CHP requires that the guarantor agree to be personally liable for all balances due or that may become due related to all visits.
4. The fees for our services are reasonable and customary fees for this region and specialty. If the patient's insurance company reimburses at a different rate than what is billed by Community Healthcare Partners, the patient may be responsible for any balance remaining.
5. We may charge reasonable fees for services related to your account including, but not limited to, returned check fees, interest on unpaid accounts, and medical record copies.
6. Should it be necessary to forward an account balance to a collection agency, the guarantor agrees to assume financial responsibility for reasonable collection costs.
7. CHP may disclose all or part of a patient's medical or financial records to third parties to obtain payment for services provided.
8. The patient's personal information will be updated at least one time per year to verify the information on file is accurate. It is the responsibility of the patient to notify our office of any changes of the personal and/or insurance information provided on this form.
9. Federal laws require that CHP submits every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. It is insurance fraud to change this information in order to try to obtain payment on a claim from an insurance company.
10. I understand and agree that any cellular or landline phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice or text and disclose the nature of communication. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.

I agree that in the event my insurance provider does not pay for some/all of the charges associated with and incurred for today's visit, I will pay any remaining balance due and that balance will be my personal financial responsibility. I understand that this only applies to CHP procedures and charges and that this excludes any and all charges incurred from third party entities as a result of laboratory testing, durable medical equipment, etc. I understand that this Medical Treatment and Financial Agreement is and will be valid for any and all services provided by Community Healthcare Partners effective from the date this Medical Treatment and Financial Agreement is signed by me and does not expire unless and until I inform our office directly that I no longer wish to have this Medical Treatment and Financial Agreement in effect.

I have been given the opportunity to read the office's Notice of Privacy Practices and have had any questions addressed concerning that policy.

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Parent or Legal Guardian (please print) Relationship

_____ _____

Parent or Legal Guardian Signature Date

**Chronic Care Management Consent :**

As a patient with two or more chronic conditions, you may benefit from a new program that CHP offers to eligible patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan.

Insurance will allow us to bill for these services during any month that we have provided at least 20 minutes of non face-to-face care of you and your conditions. You must provide your consent to participate in this program. You agree and consent to the following:

1. As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
2. We will bill your insurance for this chronic care management for you once a month. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
3. Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice.

You have a right to:

1. A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
2. Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.
3. 324 / 7 access to medical care. Our goal is to provide you with the best care possible, keep you out of the hospital, and minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals.

My signature indicates I agree to participate in CCM if I am eligible.

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Patient/ Personal Representative/ Guardian – Please Print Name

_____ _____

Patient/Personal Representative/Guardian (Signature or key if electronic) Date