PATIENT TREATMENT AGREEMENT AND CONSENT TO TREAT

Welcome to Jennifer Reed NP, LLC. Please read this document which contains important information about my professional services and business policies. A Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI), is also posted in the reception area.

The law requires that I obtain your signature acknowledging that I have provided you with this information and that you have agreed to its terms. When you sign this document, it will represent a contract between us. You may revoke this contract in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or monies owed in connection with treatment.

Please note that currently all visits are via Telehealth using Spruce Communications, unless otherwise specified by our office.

_____(initial) I understand that unless otherwise specified by the office, my appointment will be conducted via Telehealth using Spruce Communications.

Payment of Service

Payment is required at the time of each visit and I accept cash, check, credit, debit, FSA and HSA cards as forms of payment. There will be a $25 charge for any returned check. You will be responsible for the fees that are charged in connection with your treatment. My fee is $225.00 for the initial visit and $150.00 for any visit following. I will submit claims directly to insurance companies for which I am a contracted provider.

I cannot guarantee payment by your insurance company. If your claim is not paid, it will be your responsibility. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon in advance, I have the option of using legal means to secure the payment. This may involve employing the services of a lawyer or agency for collection purposes. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services and the amount due or other PHI allowed by HIPAA (Health Insurance Portability and Accountability Act).

I agree to the following billing/practice stipulations:

_____(initial) My copay will be billed the day before or day of my appointment, if my payment does not clear, I will be contacted for another form of payment. If I have not met my deductible, I understand the entire visit fee will be charged instead. This fee is based on individual contracted rates with your individual insurance. Should we cancel your appointment for any unforeseen reason, your payment on file will be reimbursed.

_____(initial) Failure to cancel an appointment 24 business hours Monday thru Friday prior to the scheduled time will result in a $75 fee. You may notify us via text to the main practice phone line at 816-631-4933. Communications are timed and date stamped

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_____(initial) Every effort is made to communicate in a timely fashion; however, I understand provider contact is not available outside of the clinic hours. Normal business hours are Monday thru Friday 8 am to 5 pm. Most calls received prior to 12:00 noon are returned the same day, however, calls made after that time may be returned the following business day. Most non-urgent questions should be reserved to the following scheduled appointment. In the event of an emergency, I understand I should call 911 or go to the nearest Emergency Room for assistance.

_____(initial) Prescription refill requests should be requested directly by your pharmacy. Please have them fax 816-264-6926 all refill requests or medication inquiries on your behalf.

Fees for Additional Services:

Your insurance company does not typically reimburse for activities that are not a part of direct patient care. The following is a list of some activities where an additional fee is required to be paid in advance.

1. Copying your clinical record (rate based on prevailing community standard)
2. It is preferred that most medical accommodation, FMLA, letter or report, or other paperwork be completed during a patient visit to ensure accuracy, any such paperwork not completed during a regular visit may be charged an additional fee up to $175 an hour.
3. Time spent away from the office to testify in court ($175 an hour).
4. Consultation with other entities including but not limited to attorney, school, disability insurers, workmen's compensation ($175 an hour).

_____(initial) I understand the above costs required for any additional services by Jennifer Reed.

CONFIDENTIALITY

The law protects the privacy of all communications between the patient and the provider, social worker, or other medical provider. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements by HIPAA. Your signature on this agreement provides consent for release of information consistent with HIPAA and state law.

A summary of the circumstances in which I may disclose private health information (PHI) without your consent is as follows:

1. If there is a situation that is potentially life threatening.
2. When child abuse is known or suspected. (Reporting required by state law).
3. When the abuse of an elderly or dependent person is known or suspected. (Reporting required by state law).
4. If you commit a crime against a staff member or another person on the premises.
5. If you bring charges against, or sue, your provider.
6. When ordered by the court.

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7. In some cases, details of your treatment may be discussed with another clinician for the purpose of consultation. When this is done, no identifying information will be included (ie, the patient is anonymous).
8. In some cases, records may be audited by the quality improvement activity of your insurance company.
9. If it becomes necessary to refer your account to a collection service. Only information to pursue collection will be released.

_____(initial) I understand the above circumstances in which Jennifer Reed does not need my permission to disclose private health information.

TELEHEALTH AGREEMENT

Due to the worldwide pandemic SARS-CoV-2, currently all patient appointments are conducted via Telehealth using the HIPAA protected Spruce Communications App. Please review the following statements and initial:

1. I understand that I am required to use the Spruce Communication desktop, IOS or Google app for my telecommunication between my provider and myself for evaluating, testing, and diagnosing my medical conditions.
2. I understand that in the event technical difficulties occur during my telehealth session, my appointment may not be started or ended as originally intended.
3. I accept that my provider can contact interactive sessions via video call; however, I am informed that the sessions can be conducted via regular voice communication (phone call) if the technical requirements such as internet speed are unable to be met.
4. I understand that my current insurance may not cover the additional fees of the telehealth practices, in this circumstance I may be responsible for any fee that my insurance company does not cover.
5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in any of these, my information will follow the office confidentiality policies as stated in this form.

_____(initial) I agree to the above terms and conditions that require my compliance to be serviced via Telehealth.

PARENTS OF MINORS ONLY

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Parents will need to sign a permission to treat form for services provided to a minor. In divorced families, patients under 18 need the consent of the custodial parent(s). A copy of the divorce decree may be requested prior to initiating evaluation and treatment.

I verify that I do have legal custody of this child_____(initial).

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APPROVAL FOR DISCLOSURE

Patient Consent to Exchange Information with My Primary Care Physician, Therapist or other Specialist.

HIPAA policy allows collaboration between healthcare providers regarding your care. By my initials below, I authorize exchange of information with my/my child's Primary Care Physician, Therapist, or other healthcare provider. I place no limits on dates, history of illness, diagnostic and therapeutic information, including treatment for alcohol and/or drug abuse.

Please list providers/individuals that you would like permission to collaborate or release information regarding your care:

Physician/Therapist name: _____

Phone:_____**Fax:**_____

Physician/Therapist name: _____

Phone:_____**Fax:**_____

Family Member Name (spouse, parent, child, significant other):_____

Relationship:_____**Phone:**_____

_____(initial) I hereby authorize the offices of Jennifer Reed to disclose my medical records, genetic results, and labs to the above parties. In the event I want to change the name of a physician or family member that has permissible disclosure, it is my responsibility to contact the office of Jennifer Reed, and or submit a new form. I have completed in full the information above to the best of my knowledge and ability.

If any of these policies or procedures cause problems or seem confusing, please speak with me, so that I may clarify them for you. I make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. I have no control over what they do with the information. In some cases, they may share the information with a national medical database. By signing this Agreement, you agree that I can provide the necessary information to your insurance carrier or other designated third-party payers such as Medicare to process claims and for quality assurance activities.

By signing the agreement below I am acknowledging that I have reviewed the entirety of this Patient Treatment Agreement and Consent to Treat document. I have read these policy statements and having been informed to my satisfaction, I give consent to treatment and/or evaluation by Jennifer Reed APRN. I understand that by signing this agreement I am acknowledging that I understand the content on this form and agree to comply with all aspects of it.

_____

Patient Signature **Date**

_____

If Patient is a Minor (Guardian Signature) **Date**

NEW CLIENT INFORMATION

Please complete the following new client paperwork prior to your first appointment. If you have had any lab-work in the past year, please obtain a copy and bring it to your first appointment, or you can have it faxed to our office 816-264-6926 by your first appointment to assist in your care.

CLIENT INFORMATION

Name (*Last, First, MI)*: _____ **DOB:** _____ ☐ M ☐ F

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address:_____ **City:**_____ **State:**_____ **Zip**:_____

Phone:_____ **Email:**_____

Emergency Contact Name:_____ **Relationship:**_____**Phone:**_____

INSURANCE INFORMATION

Insurance: _____ **ID#**: _____ **Group #**:_____

Policyholder Name (if not client): _____ **Relationship to client**:_____ **Phone**:_____

Secondary Insurance: _____ **ID#**: _____ **Group #**:_____

Policyholder Name (if not client): _____ **Relationship to client**:_____ **Phone**:_____

CLIENT REPORT OF PROBLEM

Briefly describe your reason(s) for seeking help:_____

_____

How long have you had the issue? _____

What other ways have you tried to deal with this problem? _____

_____

MENTAL HEALTH MEDICAL HISTORY

OUTPATIENT COUNSELING/PSYCHIATRY

Therapist Name:	Dates:	Results (helpful/unhelpful)

Psychiatrist/Psychiatric NP Name	Dates:	Results (helpful/unhelpful)

INPATIENT TREATMENT

Where:	Dates:	How long:

FAMILY HISTORY

Relationship	Emotional Problem(s)

PRIOR PSYCHIATRIC MEDICATIONS

Medication Name:_____
Did it help? □ Yes □ No □ Not sure **Year taken:** _____ **For how long:** _____
If you had a negative reaction, please explain: _____
_____

Medication Name:_____
Did it help? □ Yes □ No □ Not sure **Year taken:** _____ **For how long:** _____
If you had a negative reaction, please explain: _____
_____

Medication Name:_____
Did it help? □ Yes □ No □ Not sure **Year taken:** _____ **For how long:** _____
If you had a negative reaction, please explain: _____
_____

Medication Name:_____
Did it help? □ Yes □ No □ Not sure **Year taken:** _____ **For how long:** _____
If you had a negative reaction, please explain: _____
_____

CURRENT MEDICATIONS

Medication Name	Dose:

ALLERGIES TO MEDICATIONS

Medication	Reaction

OTHER MEDICAL CONDITIONS

Diagnosis	Year