— PLATTSMOUTH —
HOMETOWN HEALTH

• 306 N 7th St. Plattsmouth, NE 68048
• Ph: 402-298-5775 • Fax: 402-500-3342
• info@plattsmouthhealth.com
• plattsmouthhealth.com

Patient Name:_____ DOB:_____ Date:_____

CONSENT FOR TREATMENT

1. Acknowledgment of Treatment
I knowingly and willingly authorize the professionals at Plattsmouth Hometown Health, LLC to review my past medical history, current medical history, and any pertinent data relevant to my health care. Furthermore, I understand that all medical care provided at Plattsmouth Hometown Health, LLC is performed by an Advanced Practice Registered Nurse (APRN). I hereby authorize the nurse practitioner and their designated healthcare team to perform medical examinations, treatments, and procedures as deemed necessary for my care. This includes but is not limited to assessments, diagnosis, therapeutic interventions, proposed treatments, and preventative care. Having this knowledge, I knowingly authorize Plattsmouth Hometown Health, LLC to proceed with my care.

2. Risks and Benefits
I understand that no medical treatment is entirely without risks and that there are risks and benefits to any form of healthcare. I authorize the nurse practitioner to inform me of any known risks associated with any treatment or therapeutic interventions, including possible complications or side effects.

3. Confidentiality
I understand that my health information will be kept confidential according to state and federal regulations (e.g., HIPAA). I consent to the use of my medical information for treatment, payment, and healthcare operations as necessary.

4. Right to Withdraw Consent
I understand that I have the right to refuse or withdraw consent for treatment at any time, without penalty or loss of benefits to which I am otherwise entitled.

5. Automated Technology
I understand that this practice uses automated technology to assist with documenting my medical visits. This technology will only document information related to my care, which will then be reviewed and verified by my healthcare provider before being added to my medical record. I am aware that my medical information will be kept confidential and handled in accordance with the current HIPAA laws. I understand that I have the option to decline the use of this automated technology during my visits.

6. Telehealth and Electronic Communication
I consent to the use of telehealth services and electronic communication for consultations and follow-up care when necessary. I understand that these services will be conducted in compliance with applicable privacy laws.

Signature of Patient/Guardian: _____

Printed Name of Patient/Gaurdian: _____

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PRIVACY NOTICE

The privacy notice (HIPAA) describes how medical information about you may be used and disclosed and how you can get access to that information. We are committed to maintaining the privacy of your protected health information (PHI). This includes information about your health and the treatment that you receive. A health record is created that details the care and services you receive in this office to provide you with high-quality healthcare. This notice is to inform you how your PHI may be used and disclosed to third parties. This is also to inform you of your rights regarding your PHI. I understand that there are independent providers within the same location as Plattsmouth Hometown Health, LLC. To provide quality care, these providers may collaborate concerning your health information and treatments. If you consent to the providers collaborating about your case in detail, please indicate by checking the box next to the provider's name. Boxes left blank will indicate that you want your identity kept private during collaborative discussions.
By signing below, I acknowledge that I have received and reviewed this notice and all questions have been answered to my satisfaction in a language that I can understand.

I authorize Plattsmouth Hometown Health, LLC to release my PHI to the below listed individuals:

- ☐ Dr. Julie Howard, DC, FNP-BC
- ☐ Dr. Courtney Bradley, DC
- ☐ Other: _____ (i.e. legal names of providers, spouse, children, DPOA, etc.)
- ☐ Other: _____ (i.e. legal names of providers, spouse, children, DPOA, etc.)
- ☐ Other: _____ (i.e. legal names of providers, spouse, children, DPOA, etc.)

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Plattsmouth Hometown Health, LLC for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.
I hereby authorize Plattsmouth Hometown Health, LLC to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing. I have requested medical services from Plattsmouth Hometown Health, LLC on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

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NOTICE OF YOUR FINANCIAL RESPONSIBILITY

****PLEASE READ CAREFULLY BEFORE SIGNING****

Insurance Information:

- **We DO NOT verify your benefits or in-network status prior to your appointment.** Please remember your insurance policy is a contract between you and your insurance company, we are not a party to that contract, therefore it is **your responsibility** to verify and know your insurance benefits, eligibility, and in-network status **PRIOR** to your appointment**.**
- **If you are self-employed and/or have a marketplace plan**, it is especially important to call your insurance company to verify that the provider and/or facility are in-network.
- As a courtesy, we will bill your insurance company if we have a copy of your current valid insurance card. Please be aware that some, and possibly all, of the services provided may be "non-covered services" – **all charges deemed "non-covered" by your insurance plan are your responsibility,** we have no control over this.
- It is your responsibility to know and understand the amount of coverage you have. **You are responsible for services not covered by your policy.**
- **Co-Pays / Co-Insurance are expected at the time of service.** We accept cash, checks, money orders, credit cards, and debit cards. Payments can be made in person, by mail, or electronically.

Telephone and Digital Consults:

- **We do not provide free telephone or digital (text/email) consults**. If you initiate a question or concern that is not associated with a recent office visit (less than one week prior) then we have the right to bill you or your insurance for payment.

Private Pay / Self Pay:

- Payment must be received at the time of service in order to receive the cash price. If payment is not made at the time of service, you will be billed the full amount of the service plus a $10 per month billing fee on any unpaid balances.

No Shows / Cancelled Appointments:

- **All "no-show" appointments will be charged a fee of $25.00 to the patient.**
- We reserve the right to dismiss those from the practice that "no show" or last-minute cancel (less than 24-hour notice) 3 times or more.

Non-Payment:

- All patient balances must be paid within 30 days after you receive notification from Plattsmouth Hometown Health, LLC. If you cannot pay within that time period, contact the Front Office Manager to make payment arrangements. If we have not received payment or set up a payment plan within 60 days, your account will be turned over to collections.
- If you have an outstanding balance, even if on a payment plan, you will be charged a $10 per month billing fee. For your convenience, payment of your patient balance can be made by cash, personal check, or credit card in the office, through the mail, over the phone, or through your patient portal.

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Payment Plans:

- If you are unable to pay your account in full, we need to have a credit card to be on file and a payment plan set up to allow a payoff of the entire bill within 90 days.

Workers' Compensation / Personal Injury / Auto Accident:

- **We do not accept new patient Workers' Compensation claims,** you must be an established Primary Care Patient for at least 6 months, or 3 separate office visits, to be seen for a Workers' Compensation claim.
- If you suspect your injury is the result of a work accident, an accident report must be completed with your employer prior to any service. Any charges prior to the date of this report will be due in full as there is no guarantee of payment by Workers' Compensation.
- No guarantee of payment by insurance companies will be made. You are responsible for 100% of the costs that are not covered by insurance. We will bill the insurance companies; however, if they do not pay your claim, you are responsible for the claim amount in full.

Minor Patients:

- The adult(s) responsible for the minor is responsible for full payment at the time of service.

Please sign below to acknowledge that you have read, understand, and agree to this policy.

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Printed Name of Patient/Guardian: _____

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CONTROLLED SUBSTANCE AGREEMENT

All patients for whom we prescribe any controlled substances (narcotics, sedatives, etc.) are subject to in-office random drug testing.

Why do drug testing at all?
We test because we need to know if our patients are taking what they are supposed to be taking. We also need to know if they are taking things that they should not be taking, such as controlled substances not prescribed in our clinic, illegal drugs, or alcohol. We also need to know that our patients are compliant with what we prescribe.
What happens if I refuse the testing?
Patients who refuse drug testing will no longer be able to receive controlled substances in our clinic. We will continue to offer other pain management modalities including physical therapy, chiropractic, and psychological referral.
What happens if there are illegal drugs or drugs not prescribed by this office in my urine?
Because there can be significant, severe, and even fatal interactions between illegal drugs and those which we prescribe, we will not be able to continue prescribing controlled substances for you and will refer you for drug and alcohol counseling. If you do not attend, this will be construed to be noncompliance and grounds for dismissal from the practice.
What if I can't leave a urine sample?
If you cannot leave a urine sample at the requested time, we will draw your blood and send the specimen to the lab for testing. These results may take up to a week to be returned to us. In that time, no further medications will be prescribed unless in a dire emergency, and then only a week's worth will be prescribed.

I understand that compliance with the following guidelines is important in continuing pain treatment with the prescribers at Plattsmouth Hometown Health, LLC.

1. I understand that I have the following responsibilities:
   - I will take medications only at the dose and frequency prescribed.
   - I will not increase or change medications without the approval of my prescriber.
   - I will actively participate in return-to-work efforts and in any program designed to improve function (including social, physical, psychological, and daily or work activities).
   - I will not request opioids or other pain medicine from prescribers other than from this prescriber. This provider will approve or prescribe all other mind and mood-altering drugs unless otherwise noted in this agreement.
   - I will inform this provider of all other medications that I am taking.
   - I will obtain all medications from one pharmacy, when possible, known to this provider with full consent to talk with the pharmacist given by signing this agreement.
   - I will protect my prescriptions and medications. I will keep all medications locked and away from children.
   - I agree to participate in psychiatric or psychological assessments, if necessary.
2. I will not use illegal or street drugs. This provider may ask me to follow through with a program to address any addiction issues. Such programs may include the following; 12-step program, securing a sponsor, individual counseling, inpatient or outpatient treatment.

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3. I understand that in the event of an emergency, this provider should be contacted and the problem will be discussed with the emergency room or other treating provider. I am responsible for signing a consent to request transfer to this provider. No more than 3 days of medications may be prescribed by the emergency room or other prescriber without this provider's approval.
4. 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.
5. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
6. I understand that to receive my written prescription for certain medications, I must have a face-to-face visit with the prescriber.
7. I understand that this provider may stop prescribing opioids or change the treatment plan if:
    - I do not show any improvement in pain from opioids or my physical activity has not improved.
    - My behavior is inconsistent with the responsibilities outlined in this agreement.
    - I give, sell, or misuse the opioid medications.
    - I develop rapid tolerance or loss of improvement from the treatment.
    - I obtain opioids from another provider.
    - I refuse to cooperate when asked to get a drug screen or cannot provide one at random.
    - If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
    - If I am unable to keep follow-up appointments or keep my bill paid in full.
8. I understand the safety risks associated with being under the influence of opioids and other potentially controlled substances:
    - Decreased reaction time, clouded judgement, drowsiness, and tolerance.
    - A possible risk of danger associated with the use of opioids while operating heavy equipment or driving.
    - Side effects include but are not limited to: confusion or other change in thinking abilities, nausea, constipation, problems with coordination or balance that may make it unsafe to operate equipment or motor vehicles, sleepiness or drowsiness, aggravation or depression, breathing too slowly, overdose can stop your breathing and lead to death, vomiting, dry mouth, among others.
    - THESE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.
9. 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, diarrhea, sweating, rapid heart rate, insomnia, abdominal cramping, "goose bumps", nervousness, among others.
    - Psychological dependence - this means that it is possible that stopping the drug will cause you to miss or crave it.
    - Tolerance - this means you may need more and more drugs to get the same effect.
    - Addiction - a small number of patients may develop addiction problems based on genetic or other factors.
    - Problems with pregnancy - if I am pregnant or contemplating pregnancy, I will discuss with my provider.

Please sign below to acknowledge that you have read, understand, and agree to this document.

Signature of Patient/Guardian: _____

Printed Name of Patient/Guardian: _____