Carolyn W. Quist, D.O., P.A.
Patient Financial and Privacy Policies

Patient Name:

Financial Policies: We are dedicated to providing the best possible care and service to you and regard the understanding of your financial responsibilities an essential element of your care and treatment. For patients on insurance plans, co-pays, deductibles, and co-insurance for professional service rendered to the patient are **due at the time of service.** If the amount is known, failure to collect is deemed fraudulent activity and we will be unable to see you if you cannot pay at the time of service. For services rendered to minor patients, the adult accompanying the patient and/or parent or guardian with custody will be responsible for payment at the time of service.

Billing Agreements: We have made arrangements with most insurance carriers to accept assignment of benefits. We will generally bill the carrier on your behalf according to the following agreements: I hereby direct my insurance carrier(s) to issue payment directly to Carolyn W. Quist, D.O. for medical costs to my dependents or myself. I understand that I am responsible for any amount not covered by insurance. I hereby authorize Carolyn W. Quist, D.O. to: 1) release any information necessary to insurance carriers regarding my illness and treatment, 2) process insurance claims generated in the course of exam or treatment, 3) allow a photocopy of my signature to be used to process insurance claims, and 4) determine insurance eligibility. Patients are responsible for informing the office about changes in their insurance eligibility or a change in carrier. Patients will be asked to provide current insurance cards, social security number, and driver license prior to service. Statements will be issued for unpaid balances. Delinquent accounts greater than 90 days may be assessed an administrative fee and may be turned over to a collection agency, unless financial arrangements are made with the office manager. Patients may set up payment plans with the office manager for surgical costs with the understanding these will be completely paid prior to surgery. I further understand and agree to the following:

_____ (initial) A well woman exam, according to standard procedural books, is a visit that consists of a comprehensive preventative and maintenance exam that does not include problems that require additional coding.

_____ (initial) A problem visit consists of evaluating a presenting disease, condition, illness, injury, symptom, sign, findings, or complaint.

_____ (initial) Dr. Quist may decide to do a well woman exam and a problem visit on the same date of service. My insurance company may require me to pay an additional co-pay, co-insurance, or deductible to cover the 2nd encounter. I will be required to pay this at check out. If unable to pay I may be billed for this amount along with an administrative billing fee of $15.00.

_____ (initial) All no show office appointments and cancellations with less than 24 hours notice maybe assessed a $50.00 administrative fee. All surgery no shows or cancellations with less than 1 week notice will be assessed a $125.00 administrative fee. Payment of this balance will be required prior to scheduling any further appointments. Failure to pay may jeopardize the doctor patient relationship. Any questions concerning this policy should be directed to the office manager.

_____ (initial) **Consent:** I grant permission for Dr. Quist and staff to view my prescription history from external sources.

_____ **Consent to Treat:** I grant Dr. Quist permission to perform reasonable and necessary (initial) medical examinations, testing and treatment.

Dr. Quist makes every effort to have a chaperone present during exams. Occasionally, when short staffed, Dr. Quist might need to do the exam on her own. Please indicate whether you ___ DO or ____DO NOT give your consent to have an exam without a chaperone present.

To improve our quality of care we will be conducting surveys about your experience with Dr. Quist and her staff. The survey will be mailed to you by a third party. Please indicate whether you ____DO or ____DO NOT give your consent to have a survey mailed to you by a third party.

Privacy Practices: All medical records and other individually identifiable health and billing information used or disclosed by us in any form will be kept properly confidential according to the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

EMAIL POLICY: To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at https:mycw4.eclinicalweb.com/quge/jsp/login.jsp. Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 hours except on weekends. The service provider may delay message delivery. **Should you require urgent or immediate attention, this medium is not appropriate.** If there is a sudden change in health requiring an immediate response such as an emergency you should call 911 or proceed directly to an emergency room.

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you open all emails coming from this office so we can confirm this information was received.

All email communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff will have access to this information.

This office will not use email to communicate sensitive issues such as anything pertaining to HIV, sexually transmitted infections, substance abuse treatment, sexual assault, or mental health care. Email access to the physician is considered to be a privilege, not a right, and can therefore be revoked if the patient misuses email.

I hereby acknowledge with my signature below that: 1) I have received or read a copy of the Notice of Privacy Practices for the Office of Dr. Carolyn Quist, D.O. 2) I read and agree with the financial policies and billing agreements of the practice. 3) This office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control. 4) This office may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

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Patient or Responsible Party Signature Date

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Witness Signature Date