PRAXIS HEALTH

# PATIENT CONSENT PACKET



## PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____ Date: _____

Date of Birth: _____ Preferred Name: _____ Assigned Birth Sex: □ Male □ Female □ Unknown

Gender Orientation: □ Male □ Female □ Transgender Male □ Transgender Female □ Genderqueer □ Other □ Decline

Sexual Orientation: □ Straight/Heterosexual □ Lesbian/Gay/Homosexual □ Bisexual □ Neither Exclusively Male/Female □ Other □ Decline

Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Pacific Islander/Native Hawaiian □ White □ Unknown □ Decline

Ethnicity: □ Non-Hispanic/Latino □ Hispanic/Latino □ Unknown □ Decline

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered □ Legally Separated

Emergency Contact: _____ Relationship: _____ Phone # _____

Address, City, State, Zip: _____

Mobile #: _____ Home #: _____ Work #: _____

Email: _____ Employer: _____ Preferred Language: _____

List ALL preferred method of contact: ☐Voice ☐ Email ☐Text

## RESPONSIBLE PARTY INFORMATION *(IF DIFFERENT THAN ABOVE)*

First Name: _____ Last Name: _____ Date of Birth: _____

Address, City, State, Zip: _____

Mobile Phone #: _____ Home Phone #: _____ Work Phone #: _____

Relationship to Patient (if you are legal guardian, Power of Attorney, etc. please provide copy of your paperwork): _____

## MEDICAL INSURANCE

Primary Insurance Company: _____ Group #: _____ ID#: _____

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Secondary Insurance Company: _____ Group #: _____ ID#: _____

**Medicare Part D Prescription Drug Plan ONLY**:
***Please provide your prescription drug insurance info below:***

Insurance Company: _____ Rx Bin #: _____ Rx PCN #: _____ Rx Group: _____

# FINANCIAL AGREEMENT

## Insurance:

Praxis Health participates with many insurance providers. We agree to file claims with your insurance(s) as a courtesy. While we may have an agreement with your insurance plan, it is your responsibility to verify if your specific policy is in-network prior to scheduling an appointment and understand your coverage and benefits. Failure to do so may result in paying an increased out-of-pocket cost for your visit. Although we can provide you with a cost estimate for services, it is the insurance that makes final determination of eligibility, coverage, and total balance payable from you. We will attempt to pre-collect copays/deductibles at your appointment; any remaining balances will be due and payable within 30 days of your insurance plan determining your responsibility.

## Self-Pay:

Patients without medical insurance are required to pay a deposit at time of service. Primary care visits require a minimum $150.00 deposit, while specialist visits and diagnostic imaging require minimum $175.00. Any patient without medical insurance who has paid the deposit will receive 20% adjusted off their ending balance. Final amounts due are based upon the service(s) rendered and cannot be guaranteed prior to your appointment. Patients are billed for any balances remaining after applicable self-pay deposits and discounts are applied. The office can supply self-pay cost estimates for office visits and procedures upon request. Labs sent for processing will be billed separately and are not applicable to this policy.

## Liability Claims:

Not all locations are contracted for liability claims, please check with your office. If the reason for your visit is related to a work-related injury or auto accident, you are responsible for providing us with the claim number, date of injury, the workman's compensation or insurance carrier's name, billing address, and/or any other information necessary to file a claim. If you don't provide this information at time of service, you may be held responsible for the full balance from the visit(s). We will only bill patient's Personal Injury Protection (PIP) coverage for auto accidents, we do not bill at-fault/third party coverage.

## Fee Schedule:

The fee schedule is subject to change based on current Relative Value Units (RVU) and what is usual and customary for our service area. Services are provided on a voluntary basis and fees will be provided to you upon request. You are responsible for payment regardless of any other company's arbitrary determination of usual and customary rates. Our practice does not accept assignment of "reference-based pricing" for those companies that do not utilize an insurance network. We do offer a 20% self-pay discount off our standard fee schedule for individuals being balance-billed due to non-contracted, non-covered, or out-of-area coverage when services are rendered voluntarily. Emergent services rendered by providers involuntarily will not receive a surprise bill in compliance with state and federal laws.

## Patient Responsibility:

When an account balance becomes your responsibility, balance is due upon receipt of the first account statement from Praxis Health and its affiliates. It is your responsibility to ensure Praxis Health has current contact information on file to ensure prompt receipt of payment and avoid past due balances. If any part of the account balance becomes delinquent, then the account balance may be forwarded to an outside agency for collection. Praxis Health and contracted business associates may need to contact you for additional information or to collect any amounts you may owe. If you need to set up a payment plan, please contact our Patient Billing Advocates by e-mail at billing@adaugeohealthcare.com, toll free at (877) 708-1119, or by sending a question through the patient portal.

## Behavioral Health:

Behavioral health visits at Praxis Health are documented in your shared medical record and are accessible to your primary care team. This allows for better coordination of care. Information discussed in these visits may be shared with your treatment team if necessary to ensure safety and best quality of care. If you are seen by a behavioral health provider, it may result in additional charges. Please refer to the Insurance, Self-Pay sections above for more information on charges, and see the Acknowledgement of Privacy Practices section on following page for how your healthcare information may be used.

## Care Management:

Government billing guidelines established in 2015 for services identified as "Care Management" offer a different way to receive care when appropriate. These services are non-face to face and include but are not limited to: follow up on emergency room visits, inpatient hospitalizations, and coordination of care for ongoing chronic conditions such as diabetes, hypertension, or behavioral health. These services are rendered by multiple means, including but not limited to: phone, secure email, patient portal, or text contact directly with client or designated health contact, other health care professionals, as well as verbal and written reports. These services are billable to your insurance plan; payment processing will depend on your individual plan coverage.

## Other Fees:

A fee of $35.00 will be charged for any checks returned due to stop payment or insufficient funds. A fee of $75.00 may be charged for failure to arrive to an appointment on time or failure to cancel 24 hours prior to your appointment. If you arrive over 7 minutes late, you may need to reschedule. Multiple no shows may result in certain scheduling restrictions and/or termination from the practice

By signing below, I certify that I understand the Praxis Health Financial Agreement and accept financial responsibility for payment of any fees associated with my care. I certify that my insurance information provided is accurate and updated to the best of my knowledge. I agree to assign medical benefits paid by my insurer(s) to Praxis Health for application to my bill. I authorize Praxis Health to use and disclose my health information to facilitate payment for services I am receiving.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____

# CONSENT FOR TREATMENT

By signing below, I am requesting Praxis Health to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Praxis Health does not guarantee any outcome for any services or treatments, either stated or implied. Parents of Minors: Praxis Health will follow appropriate guidelines/reason for access per state as minor consent to care may vary by state.

Parents of Minors: Praxis Health will follow appropriate guidelines/reason for access per state as minor consent to care may vary by state.

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES POLICY:

My health information may be created or reviewed by Praxis Health or their contracted business associate partners and may be in the form of written records, electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedures, or prescriptions and similar types of related health information.

I have the right to receive and review a written description of how Praxis Health will handle my health information. This written description is known as a Notice of Privacy Practices. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Praxis Health and my right regarding my health information. I understand that the Notice of Privacy Practices may be revised, I am entitled to receive a copy of any revised Notice of Privacy Practices, and a copy or summary of the most current version is posted in the clinic, available at the reception desk, on our website, or through our patient portal.

## FORMULARY BENEFITS MANAGEMENT (PBM):

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan. I acknowledge that Praxis Health may:

- Determine pharmacy benefits, drug copays, or if prescribed medication is covered (on formulary)
- Display therapeutic alternatives within a drug class for non- formulary medications
- Determine if a health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

In summary, we will use PBM data to obtain formulary information and other prescriptions by other providers using RxHub.

By signing, I agree that I have reviewed and understand the above information regarding my consent for Praxis Health to provide treatment, my rights regarding privacy practices policy, and the use of benefits data and that I may revoke the benefits data consent in writing.

**Patient Name (Please Print):** _____ **Date of Birth:** _____

**Signature (Patient/Guardian):** _____ **Date:** _____

# PATIENT CONFIDENTIAL COMMUNICATION

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you, in confidence, by a particular method or location.

I give Praxis Health permission to leave messages regarding the below information, on the specified numbers, with the following person(s) and acknowledge that this consent expires on the patient's 18th birthday unless otherwise dictated by legal representative, and that this confidential communication outline will be revoked by written permission only or by updating this consent on file.

## You may contact me or my authorized person(s) listed below, if any, regarding:

☐ Appointments
☐ Billing
☐ Limited medical information such as normal results (*abnormal results and/or sensitive information will not be left on voicemail*), generic recommendations, generic medication information, referral status/updates on any of the following numbers provided

## You may contact me regarding the above information via:

☐ Mobile Phone
☐ Home Phone
☐ Work Phone

## You may leave ONLY the above information with the following other authorized person(s):

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

If you would like our staff to engage in more detailed discussions than outlined above regarding your medical information with a designated party—whether in your presence or not—and grant them ongoing access to the parts of your records as specified, please complete a Release of Information form. This Release of Information authorization may be revoked by following the specifications on that form.

# DIGITAL COMMUNICATIONS ACKNOWLEDGEMENT

Praxis Health and our contracted business associate (BA) partners may use a variety of methods, platforms, or technologies to contact you, provide services related to your visits, or otherwise communicate with you. These methods may include but are not limited to: phone (including wireless), email, text, virtual scribes including ambient technology, agentic technology, pre-recorded or artificial voice messages, automated dialing devices, portal, or secure/direct messaging.

Our facilities may integrate advanced tools based on AI to enhance diagnostic assessments, treatment planning, and other processes. These technologies support your care by providing additional insights; however, all final clinical decisions are made by your healthcare provider. All patient data processed by any AI system is managed with security measures in accordance with HIPAA and all applicable state regulations. Your personal information is securely maintained and used solely to improve the quality and efficiency of your healthcare. If you would like more information or prefer that your data not be used in direct patient-facing AI processes, please speak with your care team to discuss how other accommodation can be made; we are happy to work with you as best we can to ensure a comfortable experience.

When I provide an email address or text-capable number at which I may be contacted, I consent to receive messages from Praxis Health and their contracted BA partners and acknowledge that I may opt out of those text messages or emails within the text or email itself.

I acknowledge that I have been informed about the supportive role of AI in my care, and that I can discuss what direct interaction I may have with AI-based tools by talking to my care team during my visits. I understand and give express consent that I may be contacted by a variety of the above methods in order for Praxis Health or their contracted BA partners, including, but not limited to: appointment reminders, send me information about my prescriptions, obtain feedback on my experience, provide general health reminders/information, document my visit with my provider, get quick answers to commonly asked questions, or participate in programs such as care management.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____