Financial Policies, Privacy and Consents

*****Please print this page, review the contents thoroughly, sign, and bring with you to your appointment.*****

I. Consent for Treatment

I authorize Dr. Jennifer Wallace to provide ongoing medical care, treatment, and procedures as needed. I understand that no guarantees can or will be made as to the results of care, treatment, or medication prescribed.

If the patient is a minor, please tell me who besides parents/guardians is authorized to help your child access care with me. By signing this form, I give my permission that the named adult(s) listed on the line below may accompany the minor to visits and/or consent for medical care:

____

Signature of patient/guardian:____ Date: _____________

Printed name: ____

II. Financial Agreement

Billing your insurance carrier. As a courtesy, Dr. Wallace will bill insurance carriers directly. It is the patient's responsibility to notify Dr. Wallace of any changes to insurance **before** scheduled visits. Please understand that neglecting to do so may result in you being responsible for the total charges for that visit. Managing delayed or rejected claims is very costly. Resubmission of claims due to incorrect or out of date information will result in a $25 reprocessing fee.

Co-pays are due at the time of service. This arrangement is part of your contract with your insurance company. Please come prepared to pay any applicable copays via cash or check at the time of your visit. Alternatively, you may come prepared to pay via Paypal on your phone. If you are unsure if you have a copay or are unsure of the amount of your copay, please review your insurance plan details prior to the visit.

Non-covered services. At any medical facility, some or all of the services you receive may not be covered or may not be considered reasonable or necessary by your insurance provider. You agree to pay in full for any services rendered by Dr. Wallace that are denied by your insurance provider. Knowing your insurance benefits is your responsibility. Please contact your insurance provider with any questions regarding insurance coverage.

Claims submission and processing. Dr. Wallace will submit your claims and will go to reasonable lengths on your behalf to get claims paid. Dr. Wallace will ensure submitted claims are coded correctly. Sometimes, a service is denied despite accurate claims submission. As the patient, you agree to contact your insurance directly in these cases to determine the cause of non-payment. At times (especially regarding injury), your insurance company may require certain information directly from you prior to claims payment. Dr. Wallace can often guide you with these inquiries, if needed, so please ask. The balance of your claim is your responsibility whether or not your insurance company ultimately pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Other fees. Certain situations or services may result in additional fees. Examples include missed appointments, multiple records release requests, after hour visits, or home visits. These fees will be billed directly to you, and you agree to be responsible for these charges.

Payment. Full payment is due within 30 days of receipt of an eBill. Any outstanding balances more than 30 days overdue will generate a second eBill. Bills that remain unpaid 14 days after the second notification incur a fee of $15 per *per month*. If balances remain unpaid, you may be referred to a collection agency and you may be discharged from the practice. If collection procedures are required, you are responsible for their cost.

These policies and fees are representative of the usual and customary expectations for medical clinics in the Portland area. Exceptions may be made for financial hardship provided you contact Dr. Wallace within 30 days of your initial eBill. Please reach out if you need assistance.

Assignment of Benefits

By signing below, I authorize my insurance benefits to be paid directly to Jennifer Wallace MD. I certify that all information given in applying for payment under my health insurance plan is correct, and I authorize verification of coverage by Dr. Wallace. A photocopy of this authorization shall be considered as effective and valid as the original.

By signing below, I understand and agree to all financial policies and that I am ultimately financially responsible for all services provided.

Signature of patient/guardian:_______________________________________ Date: _____________

Printed name: ____

III. Consent to Release of information

I authorize Dr. Jennifer Wallace to release upon request to my insurance carriers or other reimbursing agencies information about my identity, treatment, diagnosis, prognosis, and/or other services rendered including information about substance abuse, HIV/AIDS, or other sexually transmitted or reportable diseases as permitted by law, thus releasing Dr. Jennifer Wallace of any liability for furnishing such information. I understand that information may be released through electronic or paper media.

Signature of patient/guardian:_______________________________________ Date: _____________

Printed name: ____

IV. Notice of Privacy Practices (HIPAA)

I acknowledge that I have the right to review or receive a printed copy of the Notice of Privacy Practices provided by the office of Dr. Wallace prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.

Signature of patient/guardian:_______________________________________ Date: _____________

Printed name: ____

V. Approved Methods of Communication:

Informed consent regarding email **(continued next page)**

Dr. Wallace offers patients the opportunity to communicate via email. All emails from Dr. Wallace are sent via a HIPAA compliant paid version of Gmail (G-Suite), and arrive securely into a patient's inbox. Once the email is received by the patient's email provider, however, any confidentiality is subject to the privacy standards governing the patient's own email provider. If you are concerned about confidentiality, be sure to read the privacy policy of your email provider and consider changing your email provider to one with a higher level of security if desired. There are potential risks with communication via email, including but not limited to: interception by third parties, rebroadcasting to unintended parties, and the existence of back up copies after originals have been deleted. Given these risks, transmission of highly sensitive information should never be sent via email. This includes positive results of testing for sexually transmitted disease, discussions about current drug or alcohol abuse, and sensitive mental health issues.

If you would prefer to not communicate via email with Dr. Wallace, she will invite you to set up an account via Spruce Health, a HIPAA compliant communications platform where patients can log in to receive messages and results from Dr. Wallace.

Dr. Wallace cannot guarantee that any electronic communications will be private but will take reasonable steps to protect the confidentiality of email or internet communication. If consent is given for electronic communication, it is the patient's responsibility to protect their passwords. Dr. Wallace is not liable for breeches of confidentiality caused by the patient or any third party.

Please circle your choices below:

I **DO/DO NOT** consent to the leaving of voice mail regarding medical results, appointment reminders, or billing issues. My authorized phone number for such purposes is:________________________________ . I understand it is my responsibility to update the office of Dr. Wallace as soon as my preferred number changes.

I **DO/DO NOT** consent to the leaving of e-mail regarding medical results, appointment reminders, or billing issues. My authorized email address for such purposes is: ____. I understand it is my responsibility to update the office of Dr. Wallace as soon as my preferred email changes.

Signature of patient/guardian:____________________________________ Date: ____________

Printed name: ____

VII. Acknowledgement of Practice Policies

I hereby acknowledge that I have reviewed the practice policies as posted at www.jwallacemd.com and agree to abide by these practice policies while under the care of Dr. Jennifer Wallace. This includes, but is not limited to, policies on missed appointments, narcotics, and refills. These policies are subject to periodic review and update. The latest version will always be available on the website.

Signature of patient/guardian:____________________________________ Date: ____________

Printed name: ____

Feel free to list any updated emergency contacts below:

TELEMEDICINE PATIENT CONSENT FORM

I agree to participate in telemedicine visits. By signing this agreement, I authorize the electronic transmission of my medical information so that it can be received by telephone or videoconference by Dr. Wallace.

I understand that telemedicine has limitations, and that there is no guarantee that this telemedicine consultation will eliminate the need for me to see a health care provider in person. I agree to consult with a local health care provider in person for any necessary physical examinations in order to sufficiently address my health concerns.

I understand that I can withdraw my permission for telemedicine at any time, and that if I choose to do so, no action will be taken against me, and I may still pursue a face-to-face consultation with the same doctor or other health professional.

I understand that Dr. Wallace is following the recommendations put forth by the American Medical Association regarding telemedicine consultations.

By signing below, I understand the information above and I consent to telemedicine consultation.

Signature of patient/guardian:______________________________________ Date: ____________

Printed name: ____