Laurie Otte, MSN, FNP-PC
Family Nurse Practitioner

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations

I understand that as part of my health care, Laurie Otte MSN, FNP-PC originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that the medical practice reserves the right to change its notice and practices and before implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the medical practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the medical practice has already taken action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____ _____

Signature of Patient or Legal Representative Date

☐ Accepted ☐ Denied

_____ _____ _____

Signature Title Date

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Permission to Disclose Health Information

We may disclose your health information to a family member, personal representative, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so. Please list the individuals below who have your permission to share your health information:

Name	Relationship to Patient	Conditions of Access

Signature of Patient or Legal Representative

Date

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Financial Policy

Payment Policy-It is our policy to collect payment due from the patient at the time the service is rendered. This may be your total bill, co-payment, deductible, and/or coinsurance, but we do ask for payment at the time of your visit.

Insured Patients-Our staff, as a courtesy to you, will bill your primary and secondary health insurance company. If no insurance card is presented at the time of visit, you will be considered self-pay. Please ensure your information is accurate and up-to-date. If no payment is received from your insurance company(s), you will become responsible for the total bill. Our staff will mail you a bill that contains the total cost of your service(s) and/or procedure(s) received during your visit. The health insurance company payment will be deducted from the bill when it is received. Payment of any outstanding balance is due upon receipt. Delinquent accounts are turned over to collections. Patients who have been turned over to collections are automatically dismissed from the practice.

Medicare Patients-We only accept Medicare part C - (Medicare Advantage Programs).

Medicaid Patients-We only accept AllCare CCO patients.

Uninsured Patients-We do not accept uninsured patients.

Missed Appointment Fee-There is a $25.00 fee for all missed appointments without a 24 hour notice.

Returned Check Fee-There is a $25.00 fee for all returned checks.

Forms-Patients may request their medical records for personal use one time for no charge. Subsequent requests are subject to a fee. There is no charge to payers who request medical records regarding filing claims. Other requests (attorneys, insurance companies, marijuana clinics, etc) are subject to a fee.

Our records fee is: $30.00 for pages 1-20 and an additional $0.50 for pages 21-49 and an additional $0.25 for 50+ pages.

For questions about your bill, please call Mary at (541) 471-3799 Option 2, Monday through Friday between the hours of 9 am and 5 pm.

I FULLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR FULL PAYMENT OF THE MEDICAL CARE GIVEN BY MY PROVIDER.

I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND REQUEST A COPY. I ACCEPT THE RESPONSIBILITY OF ITS TERMS.

Patient's Name (Please Print) _____

Patient's Signature _____

Date _____

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Patient Rights and Responsibilities

Patient Rights

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and/or procedure.
4. You have the right, at your own expense, to consult with another physician or specialist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment that is free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail, and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to communicate verbally or in writing with anyone outside the practice and to expect that an interpreter will be provided if language is a barrier.
11. You have the right to know the identity, professional status, and institutional affiliation of anyone treating you.
12. You have the right to request an itemized statement of all services provided to you through this practice.
13. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
14. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Patient Responsibilities

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You will be responsible for participating in the development of your plan of care.
3. You will be responsible for attending scheduled therapy and participating in activities prescribed by your treatment plan.
4. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice.
5. You are responsible for following practice rules and regulations.

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your treatment and care in our practice. Please inform any staff member.

Response to a concern/complaint will take place within 24 hours. Concerns/complaints will be monitored and the information utilized to improve our program.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

Patient_____ Date_____

Caregiver and relationship _____

Witness _____

Witness _____

(If patient is unable to document signature, two persons must be witness.)

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Practice Policies

Thank you for placing your trust in Laurie Otte MSN, FNP-PC for your healthcare. It is our pleasure to welcome you. Here is some information that may answer a few questions.

Office Hours and Appointments

Office hours and appointment times are 9:00 a.m. to 12:00 a.m. and 1:30 p.m. to 4:30 p.m. Monday through Thursday. Urgent problems will be worked in if possible. Your appointment time has been set aside for you. If you are unable to keep your appointment, we are happy to reschedule you but we ask that you notify us as early as possible. We are a small office and do not have the staff to do reminder calls. Please use your own system to keep track of your appointments. Missed appointments are a revenue loss for the business. You may be charged a fee of $25.00 for appointments missed without a 24 hour notice. After three missed appointments without calling, you will be dismissed from the practice.

We strive to stay on schedule. There is information about the visit required by your insurance carrier. We have chosen to have you fill this out prior to the appointment to allow more time discussing what brought you in, in the first place. Please arrive fifteen minutes early to complete this so you are ready for your appointment when it starts. Otherwise, your appointment time will be cut short in order to not interfere with the person's appointment after you. Arrival ten minutes after the scheduled appointment will result in rescheduling.

Prescription Refills

Please request prescription refills through your pharmacy and allow at least 48 hours to complete. They will forward your request to us electronically. Please plan ahead. If you are having problems with the refill, then call our office.

Telephone Calls

Telephone hours are Monday through Friday from 9:00 a.m. to 12:00 a.m. and 1:30 p.m. to 4:30 p.m. This is a small office. We have one provider and one office staff. We believe this business model allows for longer patient visits and this is a good thing. The downside is that there is only one person to answer your call. If we are able to answer your call, we will. Otherwise, we ask you to leave a detailed message identifying yourself, contact number and nature of your concern. We find that if you do this, we are able to call you back with answers rather than finding out your concern and then calling you back again with the answer. This allows us to help your faster and allows us to help more people. If you call and just hang up, we will not know that you have called and will not be able to help you. All messages are confidential. We have added a patient portal. This is a way to have direct communication with us and access to your chart. We encourage you to sign up for the portal all we need is your email address.

Emergency and After-Hours Calls

There is a provider on call for after-hours urgent medical advice at 541~471-8307. The on-call is not for medication refills or non-urgent matters. Laurie Otte, MSN, FNP-PC has an agreement with Three Rivers Community Hospital. If you are admitted as a patient you will be cared for by a hospitalist. A hospitalist is a provider trained to care for acutely-ill patients. We receive all notes from the hospital daily and we also have a log-in to the hospital. We are usually kept informed of your progress.

Fees and Billing

We are not a financial institution, we do not have a payment plan. Full payment is expected at the time of your visit. This may be your total bill, copayment, deductible or coinsurance. If you have insurance, we will bill as a courtesy for you. However, you are ultimately responsible for the payment.

Consultations

On occasion, we may refer you to specialist for consultation and/or management of your complex medical need. When this becomes necessary, you will be given the name of the provider or office. We will forward the necessary information to the provider(s) office and you will receive a phone call from that office regarding your appointment time. If you do not hear from them within two weeks, please let us know so we can follow up for you.

Confidentiality

Your medical record is protected information under federal HIPAA laws. Our Privacy Practices are posted.

Patient_____ Date_____

Patient Authorization for Release of Insurance Benefits

I,_____ , hereby authorize Laurie Otte MSN, FPN-PC to apply for
(patient's name)

benefits from _____, and that these benefits be made payable
(Insurance company name)

directly to Laurie Otte MSN, FPN-PC.

I certify that the information I have reported with regard to my insurance is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above billing agent (or in the case of Medicare Part B benefits, to the Social Security Administration and Centers for Medicare and Medicaid Services and/or_____ in order to determine benefits to which
(other insurance company name)

I may be entitled.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or the above carrier at any time in writing.

_____ _____

Signature Date

Authorization to Pay Benefits to Provider

I hereby authorize payment directly to Laurie Otte MSN, FPN-PC of the surgical and/or medical benefits, if any, otherwise payable to me for services described by the Attending Provider's Statement and Billing. It is understood that any monies received from the insurance company named above, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this authorization. I also understand, should this matter be placed in the hands of an attorney for collection, I am financially responsible for additional charges (attorney fees and court costs). I agree to pay interest on the outstanding balance at the rate of 1.5% per month as well as reasonable attorney fees (not to exceed 20%) and court costs with regard to the same.

_____ _____

Signature of Policyholder Date

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Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I,_____ , have received a copy of Laurie Otte, MSN, FNP-PC's
(patient's name)

Notice of Privacy Practices.

_____ _____

Signature of patient or legal guardian

Printed patient or guardian name

_____

Date

FOR INTERNAL PURPOSES ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

An emergency situation prevents us from obtaining acknowledgment

_____ Other (please specify): _____

_____

_____

_____

_____

_____