



WELCOME TO **LIFE** FAMILY HEALTHCARE, LLC!

Our providers and staff look forward to providing you with excellent healthcare and making a positive difference in your life.

This packet of information contains a lot of information. You need to read this carefully. You will sign agreements and consents based on this information. Please keep this packet with your important papers for later use.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individual following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses and Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment – We may use or disclose your information for purposes of treating you. For Example, we may disclose your information to another healthcare provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment – We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.



Healthcare Operations – We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures - We may also use or disclose your information for certain other purposes applicable by applicable laws and regulations including the following: • To avoid a serious threat to your health or safety or the health or safety of others.

- As required by state or federal laws such as reporting abused, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim, or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May make Unless You Object. Unless you instruct us otherwise, we may disclose information as described below:

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- We participate in one or more Health Information Exchanges (HIE) which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits to our facilities may be shared with the HIE's for the purposes of diagnosis and treatment. This includes health information



for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIE's may access this information as part of your treatment.

- 3. Uses and Disclosures with Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of medical notes, for most marketing purposes. You may revoke your authorization by submitting a written notice to our Office Manager. The revocation will not be effective to the extent we have already acted in reliance on the authorization.
- 4. Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to LIFE Family Healthcare, LLC's Office Manager.
 - You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concern in such item or service not be disclosed to a health insurer.
 - We normally contact you by telephone, mail at your home address and/or email if you have given your email address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
 - You may inspect and obtain a copy of records that are used to make decisions about your care or payment for care, including an electronic copy through our patient portal. We may charge you a reasonable cost-based fee for providing records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
 - You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
 - You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.



5. **Changes to This Notice** – We reserve the right to change the terms of the Notice at any time, and to make the New Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. **Complaints** – You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Office Manager.

7. **Contact Information** – If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact our office and ask to speak to the Office Manager.



No-Show, Late, & Cancellations Policy

- **"No Show"** means any patient who fails to arrive for a scheduled appointment.
- **"Same Day Cancellation"** means any patient who cancels an appointment less than 24 hours before their scheduled appointment.
- **"Late Arrival"** means getting to the clinic 10 minutes after the expected arrival time for the scheduled appointment. This ALSO includes New Patients who fail to arrive at least 20 minutes prior to appointment to fill out paperwork.

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. **LIFE Family Healthcare LLC's** goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message **at least 24 hours** before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

In the event you do not call to cancel an appointment or call the same day to cancel, you will be required to pay a non-refundable, non-transferrable fee of **\$75** during check-in for your next appointment. If you arrive late and the provider cannot work you in, you will be charged **\$75** to schedule your next appointment. *Please note because of the long appointment times for our Wellness patients, this fee for missing those services is **\$150**.* If this happens three (3) times in one year (12-months), you may be subject to dismissal from **LIFE Family Healthcare LLC**. **NO EXCEPTIONS!**

New Patients appointments do require longer appointment times and therefore if appointment is not cancelled at least 24 hours prior to scheduled appointment time patient may be refused into the practice.

Telehealth Informed Consent

Telehealth is healthcare provided by any means other than a in person face-to-face visit. In telehealth services, medical information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote monitoring are all considered telehealth services.



Electronic communication for **LIFE Family Healthcare, LLC** is used only during set times when

mandated by the office staff and providers. Telehealth visits are only provided to established LFH patients. All scheduled patients will be notified if and when telehealth services will be used.

If during a time of state and federal mandated quarantines and telehealth is the only available option for health care patient must understand in office appointments will not be offered. You have the right to “opt out” of telehealth visits. Opting out of telehealth visits will not change your ability to receive care in the future at this office; however, refills of certain medications may not be provided if telehealth visits are the only way to evaluate your progress.

Telehealth billing information is collected in the same manner as a regular office visit. Your financial responsibility will be determined individually and governed by your insurance plan to determine coverage, copays, deductibles, etc. While convenient, if YOU prefer/request a Telehealth visit but the provider does not believe it is necessary, you may be billed your regular insurance copay OR **\$50** (whichever is more), payable as described in the section titled “Insurance, Financial Arrangements, and Payments.”

All electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- The forwarding, interception, or even change of electronic communication without the users’ knowledge and despite taking reasonable measures.
- Unauthorized access by employers, friends, or others when network or connection used by the patient is not secure.
- Disruption or distortion of the transmission of medical information due to technical failures.

The patient is responsible for verifying identity and location during the telehealth service. Patients agreeing to participate in telehealth visits must take reasonable steps to protect themselves from unauthorized use of electronic communications by others. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by the patient.



Insurance, Financial Arrangements & Payments

We are committed to providing you with high-quality and affordable health care. The following are our financial expectations and arrangements:

Insurance - We participate with most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Copayments and deductibles - All copayments and deductibles must be paid when checking in for initial appointment. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered Services - Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or medically necessary by Medicare and/or other insurers. You must pay for these services in full at the time of the visit.

Some fees that are included in this and were described in previous sections are:

- If you prefer/request a Telehealth visit and the provider does not believe this is necessary, you may be billed your insurance copayment OR **\$50**, whichever is MORE.
- If you "no show," "same day cancel," or are late and the provider cannot fit you into the schedule, you will be charged **\$75** for primary care services and **\$150** for wellness services.

Proof of identity and insurance - We must obtain a copy of your driver's license and current valid insurance card as proof of your insurance policy. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Claims - Submissions - We will submit you claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance



of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not a party to that contract.

Coverage Changes - If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment - If your account is over 30 days past due, there will be a 15% service added to your bill monthly. Please be aware after 90 days any balance unpaid, will be referred to a collection agency with an additional 15% collection fee. You and your immediate family members may also be discharged from this practice. If this is to occur, you will be notified by regular certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

AS A FINAL NOTE:

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.

If you have any questions regarding this financial policy, please ask or call BEFORE you are seen by the doctor.

Patient or Guardian

Date

Print Name