FAMILY TO FAMILY
Your Home for Whole Health Care

PATIENT SERVICE AGREEMENT

Patient Legal Name _____

Patient Preferred Name _____

Date of Birth _____/_____/_____ Gender __M__F__ Social Security #_____/___/_____

Address _____
Street

_____
City State Zip Code

Email _____
OK to send unencrypted reminders / medical information / newsletters to your email? Y___N ___

Emergency Contact Name _____

Relationship to Patient _____ Phone (____)_____

Pharmacy _____
Name Address City State Zip Code

(____)_____(_____)_____
Phone Fax

FOR PEDIATRIC PATIENTS

Mother Full Name _____ Phone (____)_____
OK to leave appointment reminders / medical information on your phone? Y___ N ___

Father Full Name _____ Phone (____)_____
OK to leave appointment reminders / medical information on your phone? Y___ N ___

Child lives with Both Parents __ Mother __ Father __ Other (specify)_____

Insurance Information (required for referrals, diagnostic tests, and lab / test kit orders).
PLEASE BRING CURRENT INSURANCE CARD TO INITIAL APPOINTMENT.

Insurance Name _____

Address _____ Phone (____)_____

Subscriber Name _____

Subscriber / Group ID # _____ Member ID# _____

Understanding of Care / Terms

I understand that Family to Family (FTF) is an out-of-network practice and its physicians do not accept insurance or Medicare. I understand that FTF has opted out of Medicare program and as such I will ***not*** submit claims to Medicare. I choose to receive care from FTF with that understanding.

I acknowledge responsibility to inform FTF of any demographic (address, phone, email), marital, custodial and/or insurance changes.

I am aware of the fees. I agree to pay in full at the time of service. I understand that FTF will email an appointment reminder to the email address on record and that keeping the appointment is my responsibility. I agree to pay full price for appointments not cancelled 48 hours prior to scheduled time (with the exception of a situation deemed an emergency by FTF).

I authorize services not rendered face-to-face (including but not limited to phone and virtual consults, copy of medical records, medication refill, specialty lab kit fee) to be automatically charged to my credit card listed here or to the most recent credit card used.

FTF physicians will do their best to appropriately code and document for services, labs and tests to optimize reimbursement. I understand that FTF will provide me with an insurance ready receipt upon request.

I understand that it is my responsibility to send claim information directly to my insurance company, that some service codes are not standard, and that there is no guarantee of reimbursement from my company. FTF does not participate in insurance claim denials.

Depending upon my insurance plan I may receive reimbursement directly from them. In the event that my insurance carrier writes a reimbursement check directly to FTF, I understand that FTF will send the check back to my insurance company and request that they reissue the reimbursement check directly to me.

I have two payment choices for conventional and non-standard labs and will notify FTF of my preference ***before*** I submit to the test(s):

1. I will pay FTF directly for ordered labs at the FTF discounted rate understanding that FTF cannot bill my insurance company nor have the cost applied to my deductible.

2. I will directly pay or provide the lab service company my insurance information knowing that I may or may not be reimbursed for services.

To the best of its ability, FTF complies with standards set forth in the Health Insurance Portability and Accountability Act (HIPAA). Demographic, financial and health care information is kept private, confidential and secure and will only be used for the appropriate purposes of offering me or my child care, for making referrals, ordering diagnostic tests, or for insurance reimbursement documentation. I give FTF permission to share my (or my child's) medical information with a referring provider or my insurance company for the purpose of my (or my child's) care or reimbursement.

With that understanding, I also give FTF permission to share or discuss my (or my child's) medical information with the following persons:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

I understand that either party may discontinue this agreement as well as our doctor -patient relationship at any time for any reason. Upon request, one (1) copy of my medical record will be provided to me or to a health care provider of my choosing at no cost. Additional copies of my medical record may be purchased at a fee appropriate and customary at the time of the request.

I authorize FTF to render care to me (or my child) and provide information to me regarding my care. I understand that unconventional therapies may be offered. I agree to receive diagnostics and treatments that are considered safe but non-standard. The above statements also apply to my minor child.

I understand the services and policies set forth by FTF in this agreement and reflected on the website. I have had an opportunity to ask questions. I understand FTF policy and services are subject to change.

Credit Card Information – *I give Family to Family permission to charge my card for any payments not received at the time of service, to include but not limited to phone and virtual consults, add on labs, postage, ancillary services, and missed appointment fees. I acknowledge that FTF will keep this information confidential and secure.*

Name on Card _____

Type / Number _____

Expiration Date ____/_____ Security Code _____ Zip Code _____

MEDICAID ADDENDUM (if applicable)

□ My child is currently covered by Medicaid and meets current FTF criteria for care. I understand that FTF participates in the Medicaid program but does **not** provide primary or urgent care. I agree to pay in full for non-covered services at the time the service is rendered including extended visit time and holistic fees.

□ My child or I are currently covered by Medicaid but do **not** meet current FTF criteria for care. I understand that FTF participates in the Medicaid program but does not provide primary or urgent care. I agree to pay in full for all services rendered.

MEDICARE OPT-OUT AGREEMENT (if applicable)

By signing this document, I, _____ {print name}, agree that Family to Family has notified me of the following information, and I agree to the terms of this relationship with them.

1. Family to Family's health care providers, Drs. Lichtig, Bradt and Hanaway, have chosen **not be Medicare providers.** As a result, they are agreeing to be excluded from participating in the program under 1128 of the Social Security Act.

2. By signing this Agreement, I agree to not request that a claim be submitted on my behalf by Family to Family, and I agree to not submit a claim on my own behalf for services rendered by the physicians at Family to Family for payment under Medicare, even if such items and services would otherwise be covered by Medicare.

3. I am aware that Medigap plans to not make payments for items and services that Family to Family has furnished and that other supplemental insurance plans may also decline to make payments.

4. I agree to and am responsible for payment of services rendered to Family to Family, and Medicare will not provide reimbursement for such items or services.

5. I understand that Family to Family does not have to follow the limiting fee schedule enforced by Medicare and can determine their own fees and charges independently.

6. I understand that I have the right to have such items and services provided to me by other physicians and practitioners who have not "opted out" of the Medicare program.

7. I understand that there are a number of non-covered services that Medicare has not and does not cover such as routine physical exams.

8. I understand that the doctors at Family to Family can still order labs and diagnostic tests from facilities who are participating providers with Medicare and that those facilities can submit claims to Medicare on my behalf.

Date	Patient / Parent / Guardian Signature	Patient / Parent / Guardian Name

Date	Family to Family Staff Signature	Family to Family Staff Name