Abundant Life
HEALTH CARE

FINANCIAL RESPONSIBILITY POLICIES

PLEASE READ CAREFULLY, INITIAL AND SIGN AFTER READING EACH POLICY

We at Abundant Life Health Care are here to help you take care of your health in the best way we know how. We realize you came to us about your health, not finances. The following is to assist you in understanding Abundant Life Health Care financial policies.

_____ Initial

INSURANCE INFORMATION:

Abundant Life Health Care **DOES NOT** bill any insurance companies. Our providers are not contracted or "Preferred Providers" for any insurance carriers. **WE ARE NOT A CONTRACTED MEDICARE/MEDICAID PROVIDER.** Medicare **WILL Not Reimburse** you for services rendered at Abundant Life Health Care. If you have questions regarding your Out Of Network benefits, please contact your Insurance provider.

_____ Initial

APPOINTMENTS:

We at Abundant Life Health Care try to do things differently than most medical offices. Specifically we **DO NOT** double book appointments. This means we see one patient at a time and do not have another patient waiting. We require a **24 hours notice** if you need to reschedule or cancel your appointment. **If you miss your appointment without contacting us ahead of time or we see a pattern of missed appointments, we reserve the right to charge you a No-Show fee of $25.00 for that missed appointment.**

_____ Initial

PAYMENT AND PAYMENT OPTIONS:

Payment is due in full at the time of service.

We accept Visa, MasterCard, Check, Cash and most medical savings cards are also accepted. There is a $25.00 fee for any returned checks. Abundant Life Health Care has the right to refuse future appointment and prescription refills on delinquent accounts.

Beyond the initial appointment, a payment plan may be accepted. Each payment plan is negotiated directly between the patient and Abundant Life Health Care.

All unpaid, delinquent balances are subject to collection procedures and a fee equal to 33% of the balance due will be added to the account.

I have read, understand and agree to comply with the Patient Financial Policies.

_____

Signature of Responsible Party: Date:

_____

Print Name of Patient:

8305 W. Northview St. Boise ID 83704 * Phone: 208-433-9188 * Fax: 208-433-9372

Abundant Life
HEALTH CARE

Karole Beck, FNP-C

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record at any time. We will not disclose your record to others unless you direct us to do so in writing, or as required by law.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

This notice is available in our office for your review

I request to be contacted in the following matter (**check all that apply**).

( ) Phone Number On File
( ) OK to leave message w/detailed info.
( ) Leave message w/call back number.
( ) Written Communication or Lab Results
( ) Via Mail to home address
( ) Via e-mail on file

( ) I give permission to ALHC to release medical/billing info to:

Name:_____

Relationship:_____ Patient Initials_____

By my signature below, I acknowledge I have been informed of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual signature **Date** **Time**

_____ _____
Printed name if signed on behalf of the patient **Relationship to patient**

This form will be retained in your medical record.

8305 W. Northview St.
Boise, Idaho 83704

(208) 433-9188 ph.
(208) 433-9372 fax

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HEALTH CARE

PRESCRIPTIONS:

Initial

Karole has an expectation that you will take responsibility for knowing your medications so that we can manage your treatment safely and appropriately. Please bring a complete list of all medications and supplements with you to your appointment. It is important that we know any changes that have happened, such as you stopping a medication on your own, a specialist changing a prescription or even the emergency room or urgent care giving you something new.

Office visits are required on a regular basis for all of our patients taking prescription medication. The interval will vary depending on the type of medication prescribed. **It is state law that a patient has an appointment a minimum of every 12 months for prescriptions to be continued even if there are no changes.** Please help us uphold the laws by scheduling your routine follow up appointments in the time fame that is required.

Failure to complete required testing could result in less than accurate treatment and possible denial of a refill request. **Saliva test kits that are mailed will incur a shipping fee.**

Please contact your pharmacy if you would like to request a refill. Please allow 48-72 hours for a refill authorization.

LATE ARRIVAL FOR APPOINTMENTS:

Initial

If you are running late, please let us know. We may be able to accommodate you, or shorten your appointment time. On some occasions, we may ask you to reschedule. We want you and our other patients to get the most out of your appointments and rushing your time with us is often not in your best interest.

MESSAGES:

Initial

Your phone call is important to us, as are the patients that have scheduled an appointment that day. Calls made during office hours may require messages being taken and a return call may not occur until the end of the day depending on our schedule.

I have read and understand these Office Policies and agree to abide by them.

Signature of Responsible Party: Date:

Print Name of Patient:

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