Rose Medicine Financial Policy

Our entire staff is dedicated to providing our patients with the highest quality of care and service. It is in this spirit that we are providing you with this important information. All patients must complete our patient information forms and provide a valid state issued ID before seeing the provider. If the provider has not seen you within the past 3 years, you are considered a new patient and will be billed accordingly. Full payment is expected at the time of service unless other prior arrangements have been made. We accept cash, checks, MasterCard/Visa, Discover, and American Express. With so many health insurance companies and contracts available today, it is very difficult for our staff to know exactly what your individual contract covers. Therefore, to avoid any financial "surprises" relating to the services you receive at our office, please review your insurance policy for specific terms, conditions, and coverage limitations.

INSURANCE:
We will only accept assignment of benefits with insurance plans in which we participate. Complete health insurance information is required to process insurance claims on your behalf. All patients are required to provide all current policy information. Insurance carriers have a filing time limit. If we do not have your correct insurance information before the filing time limit, you will be responsible for all charges. Any remaining balances (such as co-pays, deductibles, and non-covered services) are your responsibility. Your policy may have a separate deductible for surgery. It is ultimately your responsibility to know what is covered through your policy. If we do not participate in your plan, you will be responsible for any NON-COVERED services under your policy and/or charges that may exceed your policy's customary free schedule. As a patient you have the right to refuse treatment.

CHECKS & COLLECTIONS SERVICES:
Returned checks will be assessed a fee of $25.00. **Balances over 90 days without pre-approved payment arrangements will be turned over to a third-party collection agency. When turned over to an outside agency for collection, collection costs of 25% will be applied to your current balance on your account.**

CANCELLATION / NO SHOWS / AFTER HOURS AND WEEKENDS:
Our office will call you two days ahead to remind you of your scheduled appointment. There will be a fee of $25 if you do not show up for the appointment. Cancellations should be done within 24 hours.

By my signature below, I acknowledge my understanding of all points in your financial policy. I authorize the release of medical information for the purpose of processing insurance claims on my behalf. I authorize payment of medical benefits directly to the provider for services provided to me. A copy of the authorization shall be considered as valid as an original signature.

Signature of Patient/Guardian: _____Relationship to patient:_____

Print name of Patient/Guardian:_____

Date:_____

HIPPA COMPLIANCE STATEMENT

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

At *Rose Medicine and or Stroke Team One*, we are committed to protecting your privacy. We comply with all federal, state and local laws. This notice describes how we use your health information. IT describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis and your treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work and improve the quality of our care.

YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information, send needed health information to other medical providers and release information to insurance companies, certain government agencies and others. We may be required to release some information even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, at your business or your answering machine or voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgement. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies. FOR MORE INFORMATION OR TO REPORT A PROBLEM if you have concerns or would like additional information, you may contact our office to speak with the office leadership.

Signature_____Date_____

Date of Service: _____

Social Determinants of Health

Patient Name: _____ **Date of Birth:** _____

As part of your visit today we would like to help with other resources for you and/or your family to maintain your health. We know that factors at home may influence your ability to be healthy. Some examples of these include access to food, housing, utilities, and transportation. Some of the questions may be personal but your answers will be kept confidential and the information is used only to help with offering resources. Our goal is to help you be healthy and have the resources to do just that.

Category	Questions	Responses (circle your answer)
Education	Do you ever need help finding a local career center and/or job training?	Yes No
Education	Do you ever need help reading hospital materials?	Yes No
Education	What is the highest level of school that you have completed?	None Elementary/Middle School High School College Graduate/Professional School
Financial Resource Strain	How hard is it for you to pay for the basics, like food, housing, medical care, and heating?	Very Hard Hard Somewhat Hard Not Very Hard Not Hard at All Patient Refused
Food	Within the past 12 months, has the food you bought just didn't last and you didn't have money to get more?	Never True Sometimes True Often True Patient Refused
Food	Within the past 12 months, have you worried that your food would run out before you got money to buy more?	Never True Sometimes True Often True Patinet Refused
Intimate Partner Violence	Within the last year, have you been afraid of someone close to you?	Yes No
Intimate Partner Violence	Within the last year, have you been humilated or emotionally abused in other ways by someone close to you?	Yes No
Intimate Partner Violence	Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by someone close to you?	Yes No
Intimate Partner Violence	Within the last year, have you been raped or forced to have any kind of sexual activity by someone close to you?	Yes No
Physical Activity	On average, how many days per week do you engage in moderate to strenuous exercise?	0 Days 1 Day 2 Days 3 Days 4 Days 5 Days 6 Days 7 Days

Date of Service: _____

Social Determinants of Health

Category	Questions	Responses (circle your answer)
Physical Activity	On average, how many minutes per session do you engage in exercise at this level?	0,10,20,30,40,50,60,70,80,90,100,110,120,130,140,150+ Patient Refused
Social Connection & Isolation	Are you now married, widowed, divorced, separated, never married or living with a partner?	Married Widowed Divorced Separated Never Married Living with a partner Patient Refused Not Asked
Social Connection & Isolation	How often do you attend church or religious services?	Never 1 - 4 times per Year More than 4 Times per Year
Social Connection & Isolation	How often do you attend meetings for the clubs or organizations you belong to?	Never 1 - 4 times per Year More than 4 Times per Year Patient Refused
Social Connection & Isolation	How often do you feel isolated from others?	Never Rarely Sometimes Often Always
Social Connection & Isolation	How often do you get together with the friends or relatives?	Never 1 Time per Week 2 Times per Week 3 Times Per Week More than 3 Times per Week Patient Refused
Social Connection & Isolation	In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?	Never 1 Time per Week 2 Times per Week 3 Times Per Week More than 3 Times per Week Patient Refused
Social Connection & Isolation	In the last 4 weeks, did getting elder care or child care make it difficult to work or study?	Yes No
Stress	How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled.	Not at all Only a Little To Some Extent Rather Much Very Much Patient Refused
Transportation	In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?	Yes No Patient Refused

Date of Service: _____

Social Determinants of Health

Category	Questions	Responses (circle your answer)
Transportation	In the past 12 months, has lack of transportation kept you from meetings, work or from getting things needed for daily living?	Yes No Patient Refused
Assistance	Do you want assistance?	Yes No
Assistance	Is it urgent?	Yes No
Depression	Over the past 2 weeks, how often have you felt down, depressed, or hopeless?	Not at all Several Days More than half the days Nearly Every Day
Depression	Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?	Not at all Several Days More than half the days Nearly Every Day

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐