Dr Karen MD & Associates
Care & Attention You Deserve

2900 S College Ave, 3G
Fort Collins, CO 80525

P: 970.300.3323
F: 970.266.8104
Contact@DrKarenMD.com

www.DrKarenMD.com

CONSENT TO TREAT

Please initial each line and sign at the end of this form:

_____I authorize medical and health care treatment by Karen Weese Bell, MD and Associates.

_____I understand that **all refills, referrals, and letters require an appointment** and will not be handled by phone/email/patient portal.

_____I understand that Dr. Karen MD & Associates will notify patients about the results of all tests that are ordered regardless of whether the findings are normal or abnormal. Occasionally, the results do not get sent to the office. **If I have undergone routine medical testing and have not received the results within 14 business days, I acknowledge that it is my responsibility to ensure that the results of ALL completed tests are reported back to me.**

_____ I acknowledge that I have reviewed a copy of the Notice of Health Information Privacy Practices, and have taken a copy if desired.

_____ I authorize Dr. Karen MD & Associates to release my medical information to any physician or health care practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request. This also extends to records regarding my child, if applicable.

_____ I understand that Dr. Karen MD & Associates respects my privacy and will only release information required to further my treatment, assist in obtaining payment, managing their own internal operations, or as specifically authorized by me.

_____I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

_____I acknowledge that if I have not been seen in 36 months I may need to re-establish as a new patient if openings are available.

_____I may revoke these authorizations in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

Name (Print):_____ Date:_____

Patient Signature:_____ (or Guardian's signature, if patient is a minor)

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FINANCIAL POLICIES

Please initial each line and sign at the end of this form:

_____I understand that **I am responsible for all charges incurred for treatments rendered even if my insurance company determines that services are non-covered or excluded.**

_____I understand that I will provide an active credit card to be securely kept on file electronically for outstanding charges.

_____Unless other arrangements are made I understand I will **receive all billing statements electronically.**

_____I understand that my account must be paid up to date prior to the next appointment.

_____I agree to a $30.00 fee for any bounced checks.

_____Cancellations or failure to show for an appointment with less than 24 hours' notice will result in a $50.00 fee. Exceptions can be made for inclement weather or situations that make it impossible to be present.

_____I understand that if my account is not paid within 90 days that I will be terminated from the practice and my account will be sent to a collections agency.

_____I agree that if this account is sent to collections, that in addition to any amount left owing to Dr. Karen MD & Associates, I will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the past due balance.

Name (Print):_____ Date:_____

Patient Signature:_____ (or Guardian's signature, if patient is a minor)

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ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

Karen Weese Bell, M.D. ("Private Practice") and _____("Patient") herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. Emails, text messages, and other forms of electronic communications (including Skype or FaceTime) may be utilized for communications between the Private Practice and the Patient, and these communications may include references to the Patient's Personal Health Information ("PHI"). The Patient authorizes the Private Practice to utilize the referenced electronic communication methods despite acknowledging that such electronic communication methods lack any guaranty of privacy. The Private Practice will engage in good faith reasonable efforts to protect the Patient's privacy while engaging in such communication methods.

2. The Patient agrees to provide accurate mobile telephone number, email address and Skype contact information to the Private Practice, and to immediately inform the Private Practice of any changes to the Patient's electronic contact information. The Patient authorizes the Private Practice to respond to any and all electronic communications that appear to be from the Patient whether or not such communications arrive from the electronic contact information the Patient provides the Private Practice.

3. Under no circumstances shall the Patient utilize electronic communications to contact the Private Practice regarding an immediate emergency or time-sensitive situation: the Patient must call 9-1-1 and/or immediately seek emergency medical attention.

4. The Private Practice values and appreciates the Patient's privacy and takes commercially reasonable security measures to protect the Patient's privacy. The Private Practice shall comply with HIPAA/HITECH with respect to all electronic communications.

5. The Patient acknowledges that electronic communications and related portable data communication and storage devices are prone to technical failures, are not 100% guaranteed to protect privacy, and can be hacked or the subject of theft or other events that may result in the loss of the Patient's information or data (including PHI). The Patient nevertheless authorizes the Private Practice to communicate with the Patient utilizing electronic communication solutions as requested and authorized by the Patient. The Patient shall hold harmless the Private Practice and its owners, officers, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or caused by electronic communication (whether encrypted or not) losses or disclosures caused by technical failures, privacy leaks, hacks, thefts, or other events not directly caused by the Private Practice.

6. The Private Practice will obtain the Patient's express written or electronic consent if the Private Practice is required or requested to forward the Patient's identifiable PHI to any third party, other than as authorized and specified in the Private Practice's Notice of Privacy Practices, or as authorized or mandated by applicable law. The

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Patient hereby consents to the communication of such information as necessary to coordinate care and achieve scheduling with the Patient and all parties responsible for providing or overseeing care. The Patient identifies the following individuals or entities as authorized to receive Patient PHI from the Private Practice in connection with authorized consulting, education, and all other aspects of supporting the Patient's care, and the Private Practice may share Patient PHI with such parties without additional written or electronic consent from the Patient.

7. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Private Practice terminating the use of electronic communication methods with the Patient, and may result in the termination of the Patient's agreement for the Private Practice services.

8. The Patient hereby consents to engaging in electronic and after-hours communications referenced above with reference to and communicating the Patient's PHI, including communication with the parties identified in paragraph 6 above.

9. The Patient understands that all electronic communication methods and platforms, while convenient and useful in expediting communication, are prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Private Practice to communicate with the Patient regarding PHI via electronic communication methods and platforms referenced in this PHI Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Private Practice will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of the Patient's PHI and HIPAA/HITECH compliance. The Patient has received a Notice Of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgement.

10. The Patient has the right to request from the Private Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Private Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information. However, the Patient's Private Practice fees may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning and burning PHI to media and distributing the media with media costs charged to the Patient; and the Private Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive), the Private Practice's actual supply costs for such equipment may be charged to the Patient and Patient agrees to pay the Private Practice such costs.

11. This PHI Agreement will remain in effect until either the Patient or the Private Practice provides written notice to the other party revoking this PHI Agreement or otherwise revoking consent to electronic communications between the parties. Such revocation will occur thirty (30) calendar days after written notice of such revocation.

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Revocation of this PHI Agreement will preclude the Private Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by the Patient. A photocopy or digital copy of the signed original of this PHI Agreement may be used by the Patient or the Private Practice for all present and future purposes.

SIGNED BY: for each participating patient over the age of 21, a signature is required below

KAREN WEESE BELL, M.D.:

Signature:

_____

Printed Name: _____

Title: _____

PATIENT:

Signature:

_____

Printed Name: _____

Relationship to Patient: _____

Signature:

_____

Printed Name: _____

Relationship to Patient: _____

Signature:

_____

Printed Name: _____

Relationship to Patient: _____

Signature:

_____

Printed Name: _____

Relationship to Patient: _____

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PATIENT VISIT
BILLING POLICY & DISCLAIMER

Please read the following policy carefully.

For new patient visits, we typically bill "**office visits**" for an initial visit. An **office visit** involves the following:

- Reviewing and recording a detailed medical history including all present and past health conditions, medications, allergies, hospitalizations, and lifestyle habits.
- Making a diagnosis or diagnoses, ordering tests, prescribing medication, referring to specialists or therapists, counseling, and/or creating or changing a treatment plan
- Assisting with managing an ongoing chronic health condition
- Medication management
- Completing paperwork like disability forms, FMLA forms, etc.

Note that depending on the clinical circumstances and time, a physical examination may be comprehensive or it may be very limited to performing only your vital signs. Sometimes office visits can be mostly discussion of health issues.

A "**wellness visit**" or **annual physical**, involves the following:

- Discussion of age-appropriate health screenings
- Discussion of age-appropriate vaccinations
- Brief review of current medications and allergies
- Physical examination
- Ordering screening tests or review of screening tests that were ordered
- Discussing health prevention

Based on the above explanations, please check **ONE** of the following:

☐ I understand that I will be receiving an **office visit** today for reasons described above and that **all applicable charges such as copays, coinsurance, and deductibles will apply, OR I am a patient with Medicare coverage.**

☐ I would like to have my first visit as a "**wellness" visit** or **annual physical**. I understand that **wellness visits are considered health screening visits only and that I will need to return to discuss health concerns as described above.** I also understand that should medical concerns need to be addressed today for safety reasons, that the wellness visit may need to be deferred to the next visit at the discretion of my clinician. ***Medicare patients are ineligible for this visit type.**

Name (Printed):_____ Date:_____

Signature:_____

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DKMD Telemedicine Consent & Terms of Service

To better serve our patients, we are now offering virtual visits. A virtual visit or "telemedicine" visit is a two-way interactive video communication and involves electronic transmission of pertinent medical information (medical records, medical images, live two-way audio and video, etc). We can use the video conferencing tools and the electronic transmission of information to assist us in the evaluation and treatment of certain medical conditions. These virtual visits are called "telemedicine" or "telehealth" visits. Telemedicine involves the use of electronic communications to enable physicians and other healthcare providers at different locations to share patient medical information for the purpose of delivering convenient, efficient, and effective patient care. The telemedicine technology systems incorporate network and software security protocols to protect the confidentiality of patient information and imaging data. In addition, the telemedicine technology includes physical, technical and administrative safeguards intended to secure and ensure the integrity of patient information.

I understand and agree that:

- I am voluntarily requesting Dr Karen MD & Associates as they may deem necessary, to treat my medical conditions.
- The telemedicine process may consist of the transmission of video or digital photographs of me, x-rays, test results, or details of my medical record.
- Transmitted data may be kept, viewed and used for the purposes of monitoring treatment and guiding healthcare provider or staff interventions. Transmitted data may become part of my medical record.
- I can refuse care through telemedicine at any time. Refusing care through telemedicine will not affect my right to care or treatment in the future.
- I can ask for an in-person consult or office visit at a future date or time with my clinician.
- Telemedicine visits are subject to the same privacy protections as in-person healthcare services.
- I will have access to all medical information resulting from telehealth services like I would if this was an in-person visit.
- Telemedicine is one of a variety of modalities for the provision of medical care that may be available to me.
- Telemedicine may involve Dr Karen MD & Associates' electronic transmission of my personal health information to distant-site providers.
- If my clinician providing the telemedicine service believes I would be better served by another form

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of service (e.g. face-to-face), I will be directed to schedule an in-person appointment with Dr Karen MD & Associates or another appropriate provider. I understand I will still be financially responsible for the cost of the telemedicine visit.

- In the event of an inability to communicate as a result of a technological or equipment failure, I agree that I will seek follow-up care or assistance at the recommendation of Dr Karen MD & Associates.
- I understand that no warranty or guarantee has been made to me with regard to any result or cure.
- I agree to pay Dr Karen MD & Associates any and all charges for this telemedicine appointment not covered by my health insurance.
- I understand it is my responsibility to pay for any item(s)/service(s) my insurance company considers to be non-covered or not medically necessary. I will be responsible for any additional balance owed, including but not limited to copay, deductible and coinsurance, upon completion of services.
- I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.
- I have read and understand the information provided above regarding telemedicine. I understand that I have the opportunity to discuss the telemedicine, including, without limitation, the risks and benefits involved, with Dr Karen MD & Associates, consultants or other allied health professionals as may be designated. I hereby give my informed consent for the use of telemedicine in my medical care.

Signed:

_____

Print Name:

_____

Date: _____

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DKMD Telemedicine Visit Criteria

For convenience, we are pleased to offer telemedicine visits for our patients! *Telemedicine visits are only for certain circumstances and cannot replace in-person office visits.*

Please read the following criteria and circle your answer to ensure that your situation is appropriate for a telemedicine visit . If you answer "no" to any questions, you should not have a telemedicine visit.

YES	NO	I am a resident of Colorado OR I will be physically located in Colorado at the time of visit.
YES	NO	I agree that I am NOT experiencing a medical emergency.
YES	NO	It is my understanding that I do NOT need a physical exam.
YES	NO	If I do need an exam, I understand my clinician will request that I schedule an in-person visit after the telemedicine visit.
YES	NO	I understand that all co-pays, co-insurance, and deductibles apply as with in-person visits. If I am a Medicare patient, I understand telemedicine visits are not a covered service and I will need to pay cash.
YES	NO	I agree that I have answered "yes" to all the above questions. If I answered "no" to any question, I will NOT schedule a telemedicine visit.

Signed:_____

Print Name:_____

Date:_____

Please leave a phone number to contact you at the time of the visit for troubleshooting in case we cannot connect virtually.

Phone Number:_____

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New Patient Questionnaire

Dr. Karen MD & Associates

Date: _____

Name: _____ DOB: _____
Address:_____
Place of birth: _____
Phone #:_____
Email:_____
Emergency Contact Person: _____
Phone Number: _____
Address:_____

Insurance provider: _____
ID #:_____Group #:_____
Employer:_____
Guarantor: _____ Guarantor's DOB: _____
Guarantor's Address: _____
Patient's Relationship to Guarantor: _____Self _____Spouse _____Child _____Other

Additional Insurance: _____
ID #:_____Group #:_____
Employer:_____
Guarantor: _____ Guarantor's DOB: _____
Guarantor's Address: _____
Patient's Relationship to Guarantor: _____Self _____Spouse _____Child _____Other

Allergies (include all medication, environmental and food allergies/intolerances and what reaction you have to each substance):_____
_____
_____

Pharmacy:_____
Branch/Location:_____
Phone #: _____

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Medications, Vitamins, Supplements, Herbs (State dosage and Frequency)

_____
_____
_____
_____
_____

List any health problems
here:_____
_____
_____
_____
_____

Have you ever had any of the following symptoms chronically or within the past six months (circle any that apply):

fatigue … lightheadedness … fever … chills … night sweats … blurry or double vision… headaches … neck pain … hearing loss … tinnitus … sore throat … runny nose … trouble swallowing … chest pain or pressure … shortness of breath … chronic cough … abdominal pain … acid reflux … constipation … diarrhea … black or bloody stool … joint pain … muscle pain … vertigo … tingling sensations … numbness … weakness … pelvic pain … pain with urination … urinary incontinence … frequent urination … trouble starting or stopping your stream … prostate problems … pain with sex and/or vaginal dryness … changes in hair or nails … depression … anxiety … mood swings

Further Details or Other Symptoms:

_____
_____
_____
_____

Please include all regular usage, including frequency and amount, both now and past use.

Tobacco:_____
Alcohol:_____
Marijuana:_____
Other drugs:_____

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Exercise, including length of time and frequency:

_____

_____

Any dietary restrictions?_____

What did you have for breakfast?_____

Lunch (if last lunch yesterday, give yesterday's lunch)?_____

Dinner yesterday?_____

Are you:

____Married?

____Partnered?

____Single?

Are you sexually active? _____ Partners men, women, or both? _____

What kind of work do you do?_____

Do you enjoy your work?_____

Do you have a spiritual practice?_____ Religion?_____

Do you feel safe at home? _____ Has anyone ever hurt you at home?_____

If so, what were the circumstances?

_____

_____

Family Medical History:

Mother:_____

Father:_____

Maternal grandfather:_____

Maternal grandmother:_____

Paternal grandfather: _____

Paternal grandmother:_____

Sisters/Brothers:_____

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Give the date of your last study, if you remember:

Colonoscopy:_____ Pneumonia shot:_____ Mammogram: _____
Flu shot:_____ Pap smear:_____ Hepatitis B series:_____
Stool blood test:_____ Hepatitis A series:_____ Tetanus shot:_____

Do you feel you have a purpose in life or a spiritual path? If so, what is it?

_____
_____

What do you do for fun?

_____
_____

What are some of your health goals over the next year or two?

_____
_____

(For women):
Last menstrual period:_____
Postmenopausal? _____
Number of pregnancies: _____
Miscarriages:_____
Deliveries:_____
Living children:_____
Abortions:_____

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Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
Patient's phone #: ( ) _____
Date of Request: _____

OR

❒ I authorize Dr. Karen MD **to release information to**:

_____
Name of Provider or Facility or Individual

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

❒ I authorize Dr. Karen MD **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) ❒ Healthcare ❒ Insurance coverage ❒ Personal ❒ Other ❒ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

❒ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

❒ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

❒ Specific information (Select one or more, as applicable)

❒ Procedure report ❒ History & physical ❒ Physical Therapy ❒ Laboratory test results
❒ X-ray reports ❒ Other _____
(Please describe.)

❒ Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

❒ This request only.

❒ One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

❒ This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____

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Welcome New Patients!

We are very pleased to have you join us at Dr Karen MD & Associates! Our practice is unique compared to many. We are a micro-practice; this means that we streamline and minimize administration by having minimal staff and use technology to our advantage. We do this so that we can spend our time and attention where it should be focused – on delivering quality relationship-based primary care to you. The following instructions are guidelines and clinic policies. **Please read through this and keep it handy as it contains important information for you to know ahead of time.** In order to deliver the relationship-based care to you, we need you to be a proactive partner.

Non-urgent Communication – Voicemails, emails, and patient portal messages*

> ***Important NOTE**: Please remember that we will have clinical discussions ONLY at an office visit. We do not perform the practice of medicine over the phone, via patient portal, or via email. Questions about scheduling and administrative issues can be done via phone or email. All clinical discussions must happen within an office visit as per office policy. This is done to protect you as a patient and us as clinicians. The best kind of medicine happens face-to-face and we want to deliver the best care possible. Thank you in advance for respecting this office policy!

- ***Main office line: 970-300-3323*** – This is the main office line with voicemail. You can leave a message with your non-urgent request or query on this line. Messages are checked once daily. Phone calls are returned within 1 business day.
- ***Email –*** Emails are checked and responded to within 1 business day. Office email: contact@drkarenmd.com. Please remember that email is not secure.
- ***Patient Portal*** – This is where you will receive secure messages from us regarding your test results. Please remember that we will use this portal to communicate with you about your test results, so make sure to activate your account! The invitation should come through your email, but you can also go to the practice website and click on the circle on the homepage that says "Patient Portal". Unless your test results are completely normal and require no discussion, we will ask you to book an appt to discuss them in person. Any other clinical discussions must happen at an office visit.

Urgent Communication – Urgent phone line with voicemail

If your issue is of a serious and urgent nature and cannot wait, please call the **Urgent/After-hours number: 970-305-3597 and leave a detailed voicemail. We will return your call as soon as possible.** Please use your best judgment and do not use this number for non-urgent issues.

- ***Urgent medical needs*:** If, for some reason, you cannot reach me, please do not wait if it is truly urgent. There are many good urgent cares in this area that can promptly address urgent medical needs.
- ***Life threatening emergencies*:** Please call 911 right away and go directly to the emergency department.

Scheduling Appointments

The easiest way to do this is online through the scheduling system on the website, www.DrKarenMD.com.

Payment Policy

Please bring your insurance card and co-payment to each appointment so that we can bill your primary insurance carrier. Please understand what your insurance does and does not cover. If you provide incorrect insurance information and a claim is rejected, then you will be charged a $30.00 fee for the extra expense of re-submitting the claim. Please note that we are sending billing statements to you electronically; you will not receive a paper statement.

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Cancellations/No-Shows:
No-shows and cancellations less than 24 hours will be charged $50. Exceptions will be made for inclement weather or situations that make it impossible to be present.

Medication Refills, Letters, and Referrals
All medication refills, letters, forms, and referrals are taken care of at the time of your office visit and **not in between visits**. Please DO NOT have your pharmacist call the office or send a fax asking for a refill. When you are running low on your medication it is a reminder that you are due for an office visit. We prescribe enough medication to last until your next office visit. Here are some answers to commonly asked questions about this policy:

- ***How much medication can I get at the time of my appointment?***
  If you have no issues and you are stable on your medication you can usually get a year supply (such as for thyroid replacement and birth control). If you have ongoing medical issues that are stable we'll want to see you every 3-12 months and will give you anywhere from 3-12 months worth of refills, depending on the issue, how long you have had it, and what we are working on. If you have issues that are not under good control, the interval for follow up will be shorter, and the refill interval will also be shorter. Make sure you ask for ALL of your refills at the time of your office visit.

- ***Why can't I just call when I'm on my last pill like at other doctor's offices?***
  The average office is inundated with requests between appointments. Because of this, they need to hire lots of staff to handle the sheer volume. Over thirty percent of the phone calls to the average office are related to medication refill requests alone. Another 20% of calls are second calls in the same day from the same person who did not get their call returned. It is also hard on the pharmacists if you wait till the last minute to ask for a refill. It is best to schedule an appointment while you still have a two week's supply left.

- ***What if I know you wrote me a longer supply than the pharmacist says I have left?***
  Tell the pharmacist to pull the original prescription and make sure that the pharmacist entered it in the computer correctly.

- ***But I forget about these things until I'm on my last pill. What can I do to help me remember?***
  Here are some tips:

    - When you only have 2 week's worth of pills left – schedule an appointment ahead of time.
    - Make sure your prescriptions all come due at the same time. Your pharmacist can often help with this. Try to get them renewed on the same cycle such as every 3, 6, 9 or 12 months. You will have them all in sequence and it becomes easy to remember the renewal date on all of them.
    - Ask each time you go to the pharmacy to make sure you know when you will run out.
    - Keep a list in your wallet so you will know if you need refills when you come to your appointments.
- ***What if I'm in a pinch? Are there exceptions?***
  Pharmacists will usually give you a 3-day supply to tide you over in an emergency. We make exceptions for situations in which you have had an emergency.

Thank you in advance for being proactive and for helping us have an efficient and streamlined medical practice. We look forward to our therapeutic partnership!

Dr Karen MD & Associates
Care & Attention You Deserve

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Notice of Health Information Practices Summary

Your Medical Record Each time you visit a hospital or physician, a record is made of your visit. This information, commonly known as a medical record, contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care. The confidentiality of your medical record is protected under the State-specific and Federal law.

Your Health Information Rights Your medical record is the physical property of the physician or healthcare facility that compiled it, but the information belongs to you. Therefore, you have rights regarding the use and disclosure of your health information.

Our Responsibilities *Dr. Karen MD* is required by the Federal Privacy Rule to maintain the privacy of your medical record and to provide you with a notice of our legal duties and privacy practices.

Uses and Disclosures for Treatment, Payment, and Health Care Operations *Dr. Karen MD* will use your health information in order to treat you. We will provide other providers or hospitals with copies of your medical record to assist them in treating you, should that become necessary. We will also use and disclose health information about you to make appointments with you. *Dr. Karen MD* will use your health information for payment. The information on a bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. *Dr. Karen MD* will use your health information for regular health operations to assess the quality of your care. *Dr. Karen MD* will disclose your health information to business associates, such as a medical transcription or billing service; so that they can perform the job we have asked them to do.

Uses and Disclosures that We May Make Unless You Object You have the right to object to certain situations in which *Dr. Karen MD* may disclose information from you medical record.

Disclosures Permitted without Consent *Dr. Karen MD* is required by state and Federal law to disclose health information from your medical record under specific circumstances.

Uses and Disclosures Specifically Authorized by You *Dr. Karen MD* expects to make other uses and disclosures of your protected health information only on the basis of specific written authorization forms signed by you.

To Report a Problem You have the right, under Federal law, to report a problem or file a complaint about how your personal health information is being handled. You can do this directly with *Dr. Karen MD* or to the Secretary of Health and Human Services in Washington, D.C.

Dr. Karen MD will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed *Notice of Privacy Practice* to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our office and have copies available for distribution.

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Confidentiality Policy

Purpose: To protect the confidentiality of patient care, personnel and business functions of Dr. Karen MD in compliance with applicable state and federal laws.

Policy: This policy applies to all employees and anyone else who is provided access to confidential information maintained by Dr. Karen MD.

The practice is committed to safeguarding the confidentiality of all information concerning our patients; our employees; and our financial information. All patient care, financial, and personnel information shall be restricted to employees on a need-to-know basis. All non-employees of Dr. Karen MD or other organizations who have signed a confidential disclosure agreement, will also have specific limits to what confidential information they shall have access to in order to provide services required by the practice. Each employee is responsible to report any suspected breaches of this policy to the Office Manager or the Physician Owners.

Procedure: Any employee of the practice will be subject to disciplinary action if she/ he:

1) Accesses confidential information other than on a need-to-know basis
2) Fails to keep all records of the practice confidential
3) Fails to prevent disclosure of confidential information to any unauthorized third party
4) Fails to report any suspected breaches of this policy to the Office Manager or the Physician Owner

Any authorized third party who fails to keep the records of the practice confidential and/or fails to prevent their unauthorized disclosure may be denied access to said records and/or subject to legal action for breaching the Confidential Disclosure Agreement.

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Surprise/Balance Billing Disclosure Form

(This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.)

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the

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most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

· Your insurer will pay out-of-network providers and facilities directly.

· Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.

· Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.

· No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a “CO-DOI” on your health insurance ID card.

Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.