PRAXIS HEALTH

PATIENT INFORMATION

Today's Date: _____

First Name:_____MI:_____Last Name:_____SSN#: _____

Date of Birth:_____Age:_____Sex:_____Gender Identity:_____Sexual Orientation: _____

Marital Status: S: _____ M: _____ D:_____ W: _____ P: _____ Email:_____Employer: _____

Race: _____ Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Primary Language: _____ If English is not primary language, is an interpreter needed: Yes / No

Street Address:_____ City: _____

State: _____ Zip: _____ County of Residence: _____

Mailing Address (If Different):_____ City/State/Zip: _____

Home #: _____Work #: _____ Cell#: _____

Emergency Contact: _____Relationship to Patient: _____Contact Number: _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

First Name:_____Last Name:_____Social Security #: _____

Address:_____ City/State/Zip: _____

Home #:_____Work #:_____Cell#:_____

Date of Birth: _____ Relationship to Patient: _____

MEDICAL INSURANCE

Primary Insurance Company:_____Group#:_____ ID#: _____

□ Subscriber is the same as the patient

Subscriber Name: _____ Subscriber Relationship to Patient: _____Subscriber DOB: _____

Secondary Insurance Company:_____Group#:_____ ID#: _____

□ Subscriber is the same as the patient

Subscriber Name: _____ Subscriber Relationship to Patient: _____Subscriber DOB: _____

Patients with Medicare Part D Prescription Drug Plan ONLY: Please provide your prescription drug insurance information below

Insurance Company: _____ Rx Bin#_____ Rx PCN#: _____Rx Group#: _____

FINANCIAL AGREEMENT

Insurance: Praxis Health participates with Medicare, Medicaid, and many commercial insurances and agrees to file claims with your primary and secondary insurance as a courtesy to you. While Praxis Health may have an agreement with your insurance plan, it is your responsibility to verify whether your specific policy is in-network prior to scheduling an appointment with our providers. Failure to do so may result in you paying an increased out-of-pocket cost for your visit. It is also your responsibility to understand your coverage and benefits. Although our office can provide you with a cost estimate for our services, it is the insurance company that makes the final determination of eligibility, coverage, and total balance payable from you. Our office will attempt to pre-collect copays and deductibles at the time of your appointment; any remaining balances will be due and payable within 30 days of your insurance plan determining your responsibility.

Cash Pay: Patients without medical insurance will be required to pay a deposit at the time of service. Primary Care Office Visits require a minimum $150.00 deposit, while Specialist Office Visits and Diagnostic Imaging require a minimum $175.00. Any patient without medical insurance who has paid their deposit will receive 20% adjusted off their ending balance. Final amounts due are based upon the length and complexity of the service(s) rendered and cannot be guaranteed prior to your appointment. Patients will be billed for any balances remaining after applicable cash pay deposits and discounts have been applied. The office can supply cash pay cost estimates for office visits and procedures upon request. Labs sent for processing will be billed separately and are not applicable to this policy.

Liability Claims: If the reason for your visit is related to a work-related injury or auto accident, you are responsible for providing Praxis Health with the claim number, date of injury, the workman's compensation or insurance carrier's name, billing address, and/or any other information necessary to file the claim. If you do not provide this information at the time of service, you may be held responsible for the full balance from your visit(s). Our practice will only bill the patient's Personal Injury Protection (PIP) coverage for auto accidents, we do not bill at-fault/third party coverage.

Fee Schedule: Praxis Health's fee schedule is subject to change based on current Relative Value Units (RVU) and what is usual and customary for our service area. Our services are provided on a voluntary basis and our fees will be provided to you upon request. You are responsible for payment regardless of any other company's arbitrary determination of usual and customary rates. Our practice does not accept assignment of "reference-based pricing" for those companies that do not utilize an insurance network. We do offer a 20% cash pay discount off our standard fee schedule for individuals being balance billed due to non-contracted, non-covered, or out-of-area coverage when services are rendered voluntarily. Emergent services rendered by our providers involuntarily will not receive a surprise bill in compliance with state and federal laws.

Patient Responsibility: When an account balance becomes your responsibility, the balance is due upon receipt of the first account statement from Praxis Health and its affiliates. It is your responsibility to ensure Praxis Health has your current contact information on file in order to ensure prompt receipt of your payment and avoid past due balances. If any part of the account balance becomes delinquent, then the account balance may be forwarded to an outside agency for collection. Praxis Health and/or contracted business associates may need to contact you for additional information or to collect any amounts you may owe. I give express agreement and consent to allow Praxis Health and/or contracted business associates to call at any telephone number provided or obtained, without limitation of wireless. Methods of contact may include using pre-recorded/artificial voice messages, texts, emails, and/or use of an automatic dialing device, as applicable. If you need to set up a payment plan, please contact our Patient Billing Advocates by e-mail at billing@adaugeohealthcare.com or toll free at (877) 708-1119.

Returned Checks: A fee of $35.00 will be charged for any checks returned due to stop payment or insufficient funds.

No Show/Late Cancellation: A fee of $45.00 may be charged for failure to show up for your appointment on time or failure to notify us of cancellation 24 hours prior to your appointment. If you arrive more than 7 minutes late to your appointment, you may be asked to reschedule.

By signing below, I certify that I have read and understand the Praxis Health Financial Agreement and accept financial responsibility for payment of any fees associated with my care. I certify that the insurance information provided is accurate and up to date to the best of my knowledge. I agree to assign medical benefits paid by my insurer(s) to Praxis Health for application to my bill. I authorize Praxis Health to use and disclose my health information to facilitate payment for the services I am receiving.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____

CONSENT FOR TREATMENT

By signing below, I am requesting Praxis Health to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Praxis Health does not guarantee any outcome for any services or treatments, either stated or implied.

Parents of Minors in the state of Oregon only: I understand that patients age 15 and older may seek and consent for treatment without parental consent (ORS 109.640).

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES POLICY

My health information may be created or reviewed by Praxis Health and may be in the form of written records, electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, or prescriptions and similar types of related health information.

I understand that I have the right to receive and review a written description of how Praxis Health will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Praxis Health and my right regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of the Praxis Health's Notice of Privacy Practices in effect is posted in the clinic, available at the reception desk, on our website, and through our patient portal.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to receive a copy of Praxis Health's Notice of Privacy Practices.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____

PATIENT CONFIDENTIAL COMMUNICATION

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Praxis Health to leave messages regarding:

___Appointments ___Billing

___Limited medical information, such as: normal results (Abnormal results and sensitive information will never be left on voice message), generic recommendations, medication information or referral status or updates on any of the following phone numbers listed on patient information form:

___ Home ___ Mobile ___ Work

And/Or with the following person(s):

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

This release will be revoked by written permission only. I understand that I must send a written request to Praxis Health in order to revoke this request. When translation services are utilized, you give express consent that it may be done using a wireless mobile device.
Parents/Guardians of Minor patients: this consent will expire on the patient's 18th birthday

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the practice.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____

FORMULARY BENEFITS MANAGEMENT (PBM) CONSENT FORM

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below, I give permission for Praxis Health to access my pharmacy benefits data electronically through RxHub. This consent will enable Praxis Health to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non- formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers using RxHub. This consent will be in place until revoked in writing.

I give permission for PBM (Rx History) Consent: Yes / No

CARE MANAGEMENT SERVICES FINANCIAL AGREEMENT

With the transformation of health care across the country, there were government billing guidelines established in 2015 for services identified as "Care Management". These services are non-face to face and include but are not limited to: follow ups for emergency room visits, inpatient hospitalizations, as well as coordination of care for ongoing chronic conditions. Examples: Diabetes, Hypertension.

These services are rendered by multiple means, to include but are not limited to: telephone, secure email, patient portal, or text message contact directly with client or their designated health contact, other health care professionals, as well as verbal and written reports.
These services are billable to your insurance plan; their payment processing will depend on your individual plan coverage. By signing below, I agree to allow Praxis Health and affiliates to provide these services.

I give permission for care management services: Yes / No

By signing below, I state that I have read and understand the above statements regarding PBM Consent and Care Management Services Financial Agreement.

Patient Name (Please Print): _____ Date of Birth: _____

Signature (Patient/Guardian): _____ Date: _____