PATIENT CONSENT FORM 2019

Consent to Treatment: I recognize that I need medical services. I consent to care and treatment at ReforMedicine, SC by its physician(s), advanced practice clinician(s), and/or medical assistant(s). I understand that the practice of medicine is not an exact science and that any treatment and/ or prescribed medication may involve risk, benefit(s), and/or side effect(s). I understand that I will be informed about the availability of alternate modes of treatment or procedures and their benefits and risks, including opting for no treatment at all, except in emergencies.

Use of Medical Information: I understand, consistent with Wisconsin and federal law, ReforMedicine, SC will share all medical information as necessary for continuation of care with any other medical institution or person(s) as allowed by law. As an example, I understand that ReforMedicine, SC does not have an in-house lab and uses an out-sourced medical laboratory. My lab work and personal information is shared to accomplish lab testing I may desire. Privacy and confidentiality of personal health information is important at ReforMedicine, SC. There are policies in place to insure that personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves this office either electronically, by fax, or paper record without specific, written authorization by you, the patient.

Financial Agreement: I acknowledge that I am responsible for all charges for services provided for me, my spouse, and/or my dependent(s) payable in full on the day that services are rendered. I understand that REFORMEDICINE, SC DOES NOT FILE OR BILL INSURANCE OF ANY TYPE because this clinic is a direct primary care practice and therefore, does not have the equipment, systems, business strategy, and personnel necessary to file insurance and collect claims.

Because ReforMedicine, SC does not affiliate with any insurance companies, this clinic can dramatically reduce fees and costs and pass the savings on to you, the patient. ReforMedicine, SC offers these reduced fees while providing excellent service and top quality personalized medical care. This practice and fee schedule will be beneficial for those in our community who do not have health insurance. It will also be appealing to those who have insurance but who do not want to wait long periods of time to be seen by a doctor on their insurance plan. In addition, this practice may be appealing to those who carry high health insurance deductibles. ReforMedicine, SC's primary goal is to make it easy for those in our community to access quality healthcare without the hassle or drawbacks associated with managed care. ReforMedicine, SC does NOT sign contracts with insurance companies that cause us to have insurance companies' interests ahead of our patients.

FOR MEDICARE PATIENTS ONLY:

At ReforMedicine, SC, our top priority is you and your health, not your insurance plan. Some services provided by us such as routine office visits, physicals, and some lab work could be covered by Medicare if we were a Medicare provider. ReforMedicine, SC has never accepted any payment from Medicare nor ever billed Medicare. Since we have opted out of being a Medicare provider, we are only able to provide your care under a private contract. This means you agree to pay ReforMedicine, SC for our services and those costs will not be reimbursed by Medicare. This only applies to the care we provide. Many times, people will ask what happens if we refer them to a specialist, to the local hospital, or for other Medicare covered products or services that we do NOT provide (i.e. wheel chairs, MRIs, X-rays, etc.) All of these services are still covered by Medicare for the patients by other health care practitioners.

Understanding the fixed income of some people on Medicare, ReforMedicine, SC has significantly reduced fees. In some cases, the fees charged may actually be less than what your out of pocket cost might be if you had Medicare billed. If you would like to be a patient at ReforMedicine, SC and understand these terms, please sign below indicating that you understand this arrangement. In addition, I will read and execute the separate private contract for care, in addition to this document, if I am such a beneficiary.

FOR ALL PATIENTS:

I acknowledge, understand and agree to the following:

I understand that failing to show up for an appointment I have scheduled, without calling or contacting ReforMedicine, SC ahead of time, represents clinic disruption to the professionals. If I should fail to call or contact ReforMedicine, SC and cancel prior to the start of the appointment, I understand NO further appointments will be scheduled for me unless I pre-pay the appointment no later than one (1) business day prior to the visit. If this should occur a second time without calling ahead to cancel or reschedule (a “no show”), **I understand that I will pay the full office visit charge for that missed appointment in addition to pre-payment for the rescheduled visit**. I have read and fully understand to my satisfaction, this entire document consisting of consent to treat, use of medical record information, financial information, Medicare notice (if applicable to me), the payment procedures of ReforMedicine, SC the “no show” policy, and agree to pay my bill in full at the end of my visit. I have had an opportunity to ask all of my questions and received satisfactory answers. **I understand that if I am a Medicare beneficiary, a separate private contract for care has been presented to me for signature and I agree to its terms before I may be treated**. I also authorize release of any necessary medical record information by ReforMedicine, SC and to any referrals on my behalf for the continuation of my care. This consent remains in full force and effect so long as I am a patient of this clinic, or unless revoked in writing by me. I also recognize and consent that on occasion, I may ask for a copy of lab work results or notes in person at checkout and these, if reasonable, may be provided to me. Anything further or different may require me signing a specific authorization for release.

_____ (Initials) By my initials, I acknowledge that I have had an opportunity to review ReforMedicine S.C.'s HIPPA Policy and also acknowledge that I should request a copy, a copy will be provided to me.

Patient:

Signature:_____

Date: _____

Print Name: _____

Parent or Guardian of Patient:

Signature: _____

Date: _____

Print Name: _____

Date: _____

Print Name of Child (if Child is Patient): _____