Patient Agreement And Consent

Patient Name:_____ **DOB:** _____/_____/_____

Welcome to the Flaton ADDept Center. It is our goal to provide you and your family with the best possible care. To do so, the following policies have been established. Please read, initial and sign the following document. If you should have any questions please address them directly with your provider or member of our admissions staff.

Client Confidentiality

The Flaton ADDept Center is dedicated to providing seamless access to a broad range of clinical services. To facilitate the highest level of clinical collaboration and coordinated services, we request you authorize the unrestricted sharing of protected health information. Should it be determined that a referral to a provider outside the practice be appropriate, an additional exchange of information shall be obtained prior to the sharing of your protected health information.

The Flaton ADDept Center will maintain a medical record of your contract for services as required by law. The confidentiality of these records is protected by law and no information which might identify you will be released without first requesting your written consent.

Initial _____

Exceptions to this confidentiality are medical emergencies, the requirements for billing health insurance plans, a judge's order to release information to a court, abuse of a child, dependent adult or elder, or in the event that you are a danger to yourself or others.

Initial _____

You may revoke your authorization to release protected health information at any time by giving written notice to the Flaton ADDept Center. Any information released prior to your revocation of this authorization shall not be a breach of your right of confidentiality. Furthermore, you have a right to receive a copy of this information.

Initial _____

Cancellation/No Show Policy

Please understand that when we schedule your appointment we are reserving time for your particular needs. We kindly ask that if you need to change an appointment, please provide notice at your earliest opportunity to provide that time for another patient.

Keep in mind that we cannot bill your insurance for missed appointments. Reminder calls/texts/emails from the center are a courtesy and are not intended to be relied upon as your sole reminder. Not receiving a call, text or email will not excuse a missed appointment. Missed appointments will be charged at cash pay rate.

- Initial appointment: If you need to reschedule or cancel your appointment with Dr. Flaton, you must do so prior to five (5) business day in advance of your appointment to avoid a $300 fee.
- Follow up appointments: Appointment(s) that you do not cancel forty-eight (48) business hours prior to your appointment will be billed at the cash pay rate of $300/hour, prorated to your scheduled time duration.
- Late arrival times of fifteen minutes or more on a frequent basis beyond your scheduled appointment(s), may be handled as a cancellation.

Initial _____

In the event that you choose to complete your professional relationship with any services of the Flaton ADDept Center, you are requested to schedule an exit appointment with Dr. Flaton

Initial _____

Please complete information continued on page 2

Patient Agreement And Consent

Patient Name:_____ **DOB:** _____/_____/_____

Prescription Refill Policy

To ensure that you receive your prescription refills on time, please note the following:
The administration requires 7-10 business days notice on all refill requests.

- In the case that Dr. Flaton is scheduled to be out of town, you will be given notice in advance by email so that you can know to request your refills prior to her absence.
- New patients and/or patients who have a practice of rescheduling appointments on a repetitive basis will be prescribed a prescription quantity which will suffice until the next scheduled appointment.

Initial _____

Credit Card on File

Our office requires a credit card on file. Your Visa, MasterCard, Discover or AMEX will be automatically processed the day of or day before your appointment for the cost of your appointment..
Appointments not kept within the Cancellation/No Show Policy (above), will be charged within 24 to 48 business hours.
I understand that my information will be securely stored for future transactions on my account.
Initial _____

Information Updates

I understand that I am responsible to notify Flaton ADDept Center of any changes in my credit card or insurance information, address, or contact details.
If I have any questions regarding my insurance or billing information, I will email my inquiry to Sandra@FlatonADDeptCenter.com.
Initial _____

Treatment Authorization

I do hereby consent to and authorize the performance of all examinations, treatments and medical services by the Flaton ADDept Center which they deem advisable. I understand that all treatment procedures are to be discussed with me and I am free to decline or withdraw from treatment at any time. I acknowledge and understand the office policies explained above.
I have been informed regarding and agree to receive the delivery of health care services via Telehealth by Janet Flaton, M.D.

I received a copy of this agreement and consent **Initial** _____
I received and read the HIPAA agreement. **Initial** _____

_____ _____
Patient's Signature **Date**

_____ _____
Parent/Guardian's Signature **Date**