DEBBIE GARRATT, FNP-C

I wish to enroll the following Adults in the Membership program:

_____
Patient Name/ Date of Birth

_____
Patient Name/ Date of Birth

_____
Patient Name/ Date of Birth

I wish to enroll the following children under the age of 18:

_____
Patient Name/ Date of Birth

_____
Patient Name/ Date of Birth

_____
Patient Name/ Date of Birth

_____
Patient Name/ Date of Birth

Phone: 208-928-8005 640 2ND Ave S B2 Ketchum, Idaho 83340

MEMBERSHIP & FINANCIAL GUARANTEE / RELEASE OF INFORMATION FOR REFERRALS

I agree to pay DEBBIE GARRATT, FNP-C all fees billed for Membership services as well as for additional services or products. All membership fees will be paid monthly or annually as elected. All extra service or product fees will be paid monthly.

Fees may be paid via credit card on file (secure) or by check which must be received no later than the 1st of any month.

It is my understanding that this office does not contract with any health insurance plans. (See Insurance Plan Disclosure later in this document)

I understand that I may pay my fees annually or monthly as outlined above. If annually the renewal will come 9 months after the initiation of my agreement. For monthly payment plans I understand that I will be asked to pay 4 months initially and then pay monthly thereafter. I realize that monthly payment plans are slightly higher than the annual rates.

I understand that I may terminate this agreement at any time with 90 days written notice. If I terminate this agreement with less than 3 months remaining on my year payment I will receive a refund for the unused months, not including the 3 month notice period.

Any referrals to an outside medical practice or service will be subject to their terms and policies. I consent to the medical information shared with that outside provider. If my insurance plan requires prior authorization or referral for such care it is my responsibility to make sure the correct referral or authorization is in place. I understand that I will be financially responsible for any and all charges directly to that provider.

I fully understand and agree to the financial and insurance policies as outlined herein.

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of patient (or guardian)***

DEBBIE GARRATT, FNP-C

HIPAA & CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I voluntarily consent to medical treatment and diagnostic procedures provided by DEBBIE GARRATT, FNP-C and personnel employed therein.

I have reviewed the Notice of Privacy Practices and Disclosures. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. A current copy of the Notice is posted on our website (www.debbiegarrattfnp.com) I understand that I can request a copy of the Notice at any time.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that DEBBIE GARRATT, FNP-C has already used or disclosed the information in reliance on this CONSENT.

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of patient (or guardian)***

Can Confidential messages (appointment reminders/ messages) be left at your:

Home: Yes _____ **No** _____ **#**_____

Office: Yes _____ **No** _____ **#**_____

Where do you prefer to receive messages? _____

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of patient (or guardian)***

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DEBBIE GARRATT, FNP-C

COMMUNICATION OPTIONS:

If you wish to receive email and text communications from our office please consider the following before providing your consent.

You have the right to have your Personal Health Information (PHI) kept secure. HIPAA requirements anticipate secure/encrypted email for transmission of any Personal Health Information (PHI). While this level of security is intended to protect your PHI encrypted email and text can be cumbersome and slow. If you seek the highest level of security, in our office this will be accomplished through in person and telephone communication, and will not be through encrypted forms of communication.

Some patients prefer to use regular email or texting in communications between themselves and this office, fully realizing that unencrypted email may not fully protect a patient's personal health information. Email or texts may be accessed by people not directly involved in your care; for example, a family member viewing your phone or computer, your employer if your email address is provided by your employer, or your internet service provider. If you wish to access us through email and text for your convenience then your agreement to the following is required.

Consent to Non-Secure Means of Communication:
I, _____, request non-secure email and text access to this medical practice. I understand that I may revoke this request at any time with 5 days' written notice by signing a new release/consent.

I would like to exchange electronic communications in the following ways: (Circle preference)

Secure Only **Telephone or in-person communication**

Preferred Telephone # _____

Non-secure & Secure

Preferred Telephone # _____

Personal unencrypted email: **Email address** _____

Personal Text (non-secure): **Cell #** _____

_____ _____
Date ***Signature of each adult patient***

_____ _____
Date ***Signature of each adult patient***

_____ _____
Date ***Signature of patient (or guardian)***

Name / Signature of Staff Member: _____

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DEBBIE GARRATT, FNP-C

OPTED OUT OF ALL GOVERNMENT PAYORS

DEBBIE GARRATT, FNP-C has opted out of and/or does not contract with any Government Payors, including, but not limited to, Medicare, Medicaid, Railroad Medicare, or Veterans Administration. Under no circumstances may these government payors or secondary insurance companies tied to these payors be billed for any services provided by this office.

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of patient (or guardian)***

COMMERCIAL AND PRIVATE INSURANCE COMPANY BILLING

DEBBIE GARRATT, FNP-C is not a participating provider with any private health insurance. If I ever bill services to my private health carrier (not a government or Medicare secondary insurance carrier which is never allowed) those services will be as an out-of-network provider.

If I ever elect to bill my insurance for any services provided by DEBBIE GARRATT, FNP-C and my insurance company categorizes services rendered to me as "non-covered" or "not medically necessary," it will in no way alter the validity of those services or my obligation to pay for those services.

Upon request, DEBBIE GARRATT, FNP-C will provide, no more often than quarterly, a summary superbill of services provided during the preceding calendar quarter. The purpose is for requesting out-of-network reimbursement under your insurance plan's policy. The total value of these services cannot exceed the money paid for medical care at this medical practice during the period for requested bills. A service fee of up to $100 per request will apply.

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of each adult patient***

_____ _____

Date ***Signature of patient (or guardian)***

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Confidential Patient Contact Person:

If you would like us to be able to share any information about you or your care you must consent in writing below.

You may revoke this authorization with 5 days' written notice at any time. Such revocation will only apply to information after the effective date of revocation which cannot be sooner than 5 days after such revocation notice is received in our office.

Name 1 _____
Relationship_____
Address_____

Telephone_____
Date of Birth _____

Name 2 _____
Relationship _____
Address_____
Telephone_____
Date of Birth _____

Check her if an Addendum A is attached to list other names. _____