SONOMA VALLEY
SPECIALTY CLINIC

_____*Terms of Financial Agreement and Assignment of Insurance Benefits*

Financial Agreement

Patients will agree to promptly pay all Sonoma Valley Specialty Clinic bills in accordance with the reimbursement rates listed in the clinic's charge description master. The patient will understand that they may review the clinic's charge description master before (or after) they receive services from the clinic. All services ordered by their physician and performed elsewhere are subject to separate billing. If any account is referred to any attorney or collection agency for collection, the patient will pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

Assignment of Insurance Benefits

The patient will assign and authorize direct payment to the clinic of all insurance and health plan benefits payable for service at the clinic. Patients will agree that the insurer on plan's payment to the clinic pursuant to this authorization shall discharge its obligations to the extent of such payment. Patients will understand that they are financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law.

____*Notice of Health Information Privacy Practices Acknowledgement*

I understand that as part of my healthcare, Sonoma Valley Hospital and its medical staff creates, receives and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that my health information may be used and disclosed by Sonoma Valley Hospital and it's medical staff to carry out my care and treatment, to obtain payment and for Sonoma Valley Hospital's health care operations. I have been provided with a copy of Sonoma Valley Hospital's Notice of Health Information Privacy Practices that provides a description of information uses and disclosures, and I have had an opportunity to ask questions about anything I did not understand. I understand that I have the right to review this notice prior to signing this acknowledgement; furthermore, I understand that Sonoma Valley Hospital reserves the right to change the privacy practices outlined in its Notice of Health Information Privacy Practices and that any changes may apply retroactively to information created while the current Notice is in effect. I understand that I may obtain a copy of the revised Notice by submitting a written request to Sonoma Valley Hospital's Medical Records Department, by requesting one in person, or obtaining a copy from Sonoma Valley Hospital's web site www.sonomavalleyhospital.com. I understand that I have the right to "opt out" of the use of my health information for directory purposes; furthermore, I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Sonoma Valley Hospital is not required to agree with the requested restrictions; if Sonoma Valley Hospital agrees to the requested restrictions, Sonoma Valley Hospital will not use or disclose information about you in any manner contrary to the terms of the restrictions. I hereby acknowledge that I

have been made aware of my rights and have received a copy of Sonoma Valley Hospital's Notice of Health Information Privacy Practices that details their intended use of my protected health information for treatment, payment, and healthcare operations. I also understand that I have the right to receive and review a written description of how the practice will handle health information about me. This written description, known as a Notice of Privacy Practices, describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel, and my rights regarding my health information.

I further understand that it is the policy of the practice to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how the practice will (1) identify, (2) detect, and (3) respond to "red flags" which are defined by this policy as including a pattern, practice, or specific account or record activity that indicates possible identity theft. I understand that the Notice of Privacy Practices is available to me upon request and that it is the policy of the practice to review and update these policies no less than annually, of which I may have a copy of the updates upon request. By signing below, I agree that I have reviewed and understand the information above.

_____ **NOTICE**: Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to:
Web: www.mbc.ca.gov | Email: licensecheck@mbc.ca.gov | Call: (800) 633-2322

____ *"NO-SHOW" APPOINTMENT POLICY*

If you are unable to keep your appointment, please call us *as soon as possible*. As a courtesy, an appointment reminder call to you is made/attempted 1 to 2 business days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for the appointment on time. We do our utmost to provide timely and efficient care, so we ask you to extend the same courtesy.

PLEASE REVIEW THE FOLLOWING POLICY:

- FOR OFFICE VISITS:
  - Notify us by **1:00 pm on the business day prior** to your scheduled office appointment or telehealth visit if you need to reschedule. Appointments which are rescheduled or cancelled without this advanced notice will be subject to a **$35.00 Late Cancellation Fee.** This will be sent to you as an invoice and/or the fee will be collected prior to rescheduling the appointment.
  - If there is no notification, then this is considered a *"No-Show"*. A **$35.00 No-Show Fee** will be assessed. This will be sent to you as an invoice and/or the fee will be collected prior to rescheduling the appointment.
  - Three "No-Shows" will require a new referral prior to being seen by the surgeon.

- FOR OPERATIONS OR PROCEDURES:
  - Reschedule **operations/procedures** with at least **FOUR (4) business days**' notice by calling our office. Do *not* call the hospital. (For example, if your operation is on a Tuesday, you will need to notify us prior to 1:00 pm on the preceding Wednesday.) A

$250.00 OR Cancellation Fee will be assessed for late cancellations or "No-shows" for operations. This will be invoiced and collected prior to rescheduling the operation/procedure.

- Arrivals more than 15 minutes after the appointment time are considered LATE.
  - Office appointments or telehealth visits will have to be rescheduled.
  - Hospital appointments will be accommodated or rescheduled at the discretion of the operating room staff.

___ TELEHEALTH NOTICE

Our secure, HIPAA-compliant Audio-Visual Telehealth platform is called doxy.me. Some Telehealth visits may also be conducted by telephone. You will be given a specific link for the surgeon's virtual waiting room. Please read the following. Your signature below provides consent to engage in telehealth.

I understand that Telehealth is a mode of delivering health care services via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, and/or care management.

I have a right to confidentiality with regard to my treatment via Telehealth under the same laws that protect the confidentiality of my protected health information during in-person consultations.

I understand that miscommunication between myself and my physician may occur via Telehealth and that the physician can only make recommendations based on the information I, the patient, has provided.

I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

I understand that if my physician believes I would be better served by in-person consultation, my physician will discuss this with me. I understand that I may request an in-person consultation in lieu of a Telehealth visit at any time.

I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my physician may record the sessions without the other party's written consent.

ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING OF ABOVE POLICIES:

Signature Today's Date Relationship to Patient