Patient Treatment Agreement

Signing a new agreement today at any Nao Medical/HFMC location supersedes patient agreements that Nao Medical/HFMC may have on file.

General Consent for Treatment: I wish to receive medical care from Nao Medical/HFMC. I hereby authorize the physicians, medical providers, allied healthcare workers, and professional staff at Nao Medical/HFMC to provide medical treatment to me or the patient named herein for whom I might be making this payment for. I agree with getting diagnostic tests and procedures, including X-rays, injections or administration of pharmaceutical products/medications, drawing of blood or getting internal exams done. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment, examination or outcome of the proposed treatment plan at Nao Medical/HFMC. I release Nao Medical/HFMC from all liability due to the loss or damage of any valuables or personal belongings.

Notice of Privacy Practices and Patient's Bill of Rights: I have read the HIPAA form and Patient Bill of Rights."

Verification of Insurance Eligibility & Insurance Authorization: I understand that if my eligibility for coverage by my insurance company cannot be confirmed and it is determined that 1 am not eligible for coverage I will be responsible for payment of all services provided to obtain authorization for services rendered. I understand that I am responsible for notifying my insurance company to obtain authorization for services rendered. I understand that all accrued charges may not be reflected at the time of check out. I may receive a statement that will detail additional accrued charges, such as unsatisfied deductible balances, laboratory, radiological services, or special procedures. I understand that all charges will be filed with the insurance information on file if provided by me at the time of the visit. Nao Medical/HFMC will file a claim to the insurance carrier that I provide them with today. Nao Medical/HFMC does not guarantee payment from my insurance carrier. It is my responsibility to know the details of my insurance policy and my covered benefits. After the insurance company has processed my claim, I will receive a bill for the amount due and I will be responsible for the billed amounts if any. I guarantee that when the claim is filed for my visit if my insurance is not active, I will be responsible for the full payment due. As per New York State law, Nao Medical/HFMC has informed me that any person who knowingly and with intent to defraud any insurance company, physician, or any other health care practitioner is committing fraud, which is a crime. NY Penal Code, Section 176.05- The failure to provide accurate information as to your insurance coverage, or the obtainment of services through deception by use of insurance IDs that constitute a fraudulent act. Such acts are subject to a civil penalty not to exceed $5000 and the stated value of the claim for each

violation. It is the policy of Nao Medical/HFMC to report all insurance fraud to the New York State Commissioner of Insurance, Insurance Fraud Bureau. I understand that I am financially responsible for any accrued charges and that a late fee of $25.00 will be assessed for each invoice that I receive every 30 days. In addition, I agree to pay any charge-back fees. If the account is referred to collection, I agree to pay all collection fees, interest, court costs, and attorney fees. At the time of the visit. I agree to pay Nao Medical/HFMC the following: 1. Co-payments as set by my insurance carrier 2. An initial fee of $100 towards my deductible (if applicable) 3. Any other amounts that my insurance co deems to be my responsibility (costs of all vaccines for preventative care, or amounts not covered by my insurance carrier either based upon my insurance plan or because my insurance card is inactive or invalid. 4. Cost for the office visit as set by Nao Medical/HFMC if I do not have valid insurance and failed to declare it at the time of my visit. 5. I acknowledge that any and all X-rays are taken at this facility are part of the medical record and property of Nao Medical/HFMC. A report of the findings may be obtained upon request. A CD containing the X-Ray film may be purchased for $15. I have the right to receive an itemized statement by mailing a written request to Nao Medical/HFMC or by calling the office at (917) 310-3371.

Assignment of Benefits: I assign the benefits payable for the physician's services to Nao Medical/HFMC to submit a claim to Medicare/Medicaid for payment.

Responsibility for Credit Dispute: I understand that if I initiate a dispute with my credit card company in regards to a payment made to Nao Medical/HFMC, that I will be responsible for the $50.00 cost (includes time, labor and chargeback fees) incurred as a result of the dispute investigation.

Responsibility for paying the copay or deductible: A $10.00 charge will be added to any patient who refuses to pay for their copay at the time of visit.

Telephone Policy, Prescription History, Patient Portal, Text, Voice Message, Web-Enabling For Patient Portal

I acknowledge, understand, and accept Nao Medical/HFMC HIPAA and patient privacy policy which exists to protect my privacy and that Nao Medical/HFMC staff will not be discussing my lab or imaging results over the phone, or with anyone else without my written consent.

I give Nao Medical/HFMC permission to access my external prescription history to enable quality medical care.

I agree to be web-enabled which will allow me to access my blood test results, keep track of

appointments, update patient demographic information and access to patient education materials at Nao Medical/HFMC. I understand and acknowledge that receipt of or use of the text messaging service from a terminal such as a mobile device is subject to any agreements I have with my cellular network carrier and any fees that they may charge, including but not limited to fees for text messages, data usage or internet access. Any and all fees are my sole responsibility and not that of Nao Medical/HFMC.

I give permission for Nao Medical/HFMC to share Nao Medical/HFMC Business Contact information via text message to me on my cell phone. (Nao Medical/HFMC Business Contact information includes a contact number, contact email, business address, website, business hours and Nao Medical/HFMC services) I have fully read and understood this consent form and the policies and procedures regarding the Patient Portal.

If you have provided your insurance information during your visit today, our billing team will send a claim to your insurance company shortly after your visit. Once the claim is successfully processed, your insurance company will send us a statement with the amount you owe. If you have a remaining balance, you will receive a statement with the amount you owe as a text message and in the mail. For your convenience, we will charge the credit card you have left on file with us. There will be approximately 15 days from the time you receive the statement to the time your card is charged. If you would like to make other arrangements to pay off your balance or have questions regarding your statement, please contact us before the date on your statement. Our billing team's email address and phone number will be listed on the statement.

By signing this form you are consenting to leave a credit/debit/HSA or FSA card on file with Nao Medical/HFMC. Your information will be stored using the same encrypted, secure software used to store your medical records. You are also consenting to have your credit/debit/HSA or FSA card charged for any remaining balance you may owe. I have read and agreed to the Credit Authorization.

Medical Care:

The evaluation and treatment I am receiving today are being rendered on an urgent care basis only. Follow up care by my own doctor or at a follow-up visit at Nao Medical/HFMC for the specific problem identified recommended for re-examination and for any new or continuing problems that might be getting worse is difficult to diagnose and treat all aspects of an injury or illness in one visit at Nao Medical/HFMC.

All X-Rays done at Nao Medical/HFMC will be interpreted by a Radiologist to confirm the initial interpretation by the medical provider. If there is a change in the diagnosis, you and/or your doctor

will be notified by one of the medical staff. Fractures or abnormalities may not show on X-Rays for several days. I understand that if my symptoms persist or get worse, then I must follow up with Nao Medical/HFMC or my own Primary Care Physician ASAP.

I understand that I need to follow all the instructions given to me today.

I understand if my symptoms worsen or continue, then I must return to the Nao Medical/HFMC or see my own Primary Care Physician immediately. I am aware that I can reach Nao Medical at (917) 310-3371.

Health Information Exchange

I give consent to all the Health Information Exchange participants listed on the HIE website and Care Everywhere Providers to access all of my electronic health information through the HIE and I give consent to all employees and agents of Nao Medical/HFMC to access all of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact in sheet, including providing me any health care services, including emergency care.

As a patient at Nao Medical, you are an integral part of our community, and we ask for your partnership in upholding these principles.

1. Respect for Staff: I will treat all healthcare staff, including physicians, nurses, administrative personnel, and support staff, with courtesy, respect, and professionalism at all times.

2. Non-Discrimination: I will not discriminate against or harass any staff member based on their race, color, religion, gender, sexual orientation, national origin, age, disability, or any other protected status. Discriminatory behavior or language will not be tolerated.

3. Sexual and Physical Advances: I understand that any form of sexual or physical advances, harassment, or inappropriate behavior directed towards healthcare staff is strictly prohibited. This includes unwelcome sexual comments, gestures, advances, or any form of physical contact that is not part of necessary medical care. Violation of this policy may result in immediate termination of my treatment, discharge from practice, and legal action if necessary.

4. Confidentiality: I will respect the privacy and confidentiality of all healthcare staff, fellow patients, and any sensitive information I may become aware of during my treatment. I will not share or disclose any confidential information.

5. Complaint Procedure: If I have concerns or complaints regarding the conduct of any healthcare staff member, I will follow the established complaint procedure at Nao Medical, which may involve reporting the issue to the appropriate supervisor or the facility's administration.

6. Patient Responsibilities: I understand that as a patient, I have certain responsibilities to my own healthcare, including providing accurate information about my medical history, complying with recommended treatments, and following the facility's policies and procedures.

7. Consequences of Violation: I acknowledge that any violation of this patient treatment agreement, including engaging in sexual or physical advances against staff, may result in the termination of my treatment at Nao Medical, and I may be subject to legal action as appropriate.

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Name	**Signature**	**Date**