

Patient Consent Form:

Consent for Medical Treatment. I give consent to ADAPS healthcare, its staff, medical providers and other practitioners (the Practice) to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by the practice for my health and well-being.

Authorization of Payment of Insurance Benefits. I authorize payment to the practice of all monies end/or benefits to which I may be entitled by government agencies, insurance carriers or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/ all medical records about me for the purpose of payment of the service rendered to me.

Signature on file (Medicare patients). I certify that the information given to me in applying for payments under Medicare is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/ or Center for Medicare and Medicaid services, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that the payment or authorized benefits be made to me or on my behalf to the practice for services but provided by the practice.

Financial agreement. I agree that in consideration of the services rendered to me, to pay all the amounts for which I am financially responsible, in accordance with the rates in terms of the practice. I understand that to the extent permitted by law, where insurance or other third-party benefits are insufficient to pay for all the services rendered, that I will be responsible for the payment of any balance due as determined by the respective provider of services, including deductibles, copayments, coinsurance or other fees required by insurer, HMO or other benefit plan. I understand that if I have not provided the practice with accurate and current information regarding my insurer, HMO or other benefit plan/ third party payer which provides me with health care coverage, I will be personally responsible for the cost of all care rendered by the practice. I understand that the practice may require a consumer credit report in connection with the collection of accounts. By signing this form, I am providing the practice as well as its collection agency/ attorney with a written authorization to obtain a consumer credit report. I agree to pay all bills when presented. Should the account be referred to an attorney for collection, I shall pay all reasonable attorney fees and collection expenses. I understand that there will be a \$25 charge for all returned checks.

Authorization for release of information. By signing below I authorize the practice to release my health information: 1 to any requesting healthcare provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; 2 to any person or entity which may be responsible for billing/ collection of claims for medical services or products; 3 to any person or entity which is, or may be liable to the practice or me for all or part of the practices charges, including but not limited to, insurance companies, HMO's or third party payers; four to any government agencies or other organization responsible for oversight of the practice or a third party payer; 5 for the practices normal healthcare operations. I authorized the practice to communicate with me through text or e-mail even if not encrypted, and to allow the individuals listed above to access such information through any medium including over the Internet, even though the emails may not be encrypted, and through the practice's electronic medical records.



Filming. Understand that photographs or other images of me may be recorded for the practice's treatment and quality assurance purposes. To the extent that such images identify me, I understand that they shall receive the same confidentiality protection as my other health information.

Acknowledgement of notice of privacy practices. I have received a copy of the practices notice of privacy practices, and have had the opportunity to receive assistance and the understanding and exercising these rights. Our practice uses a HIPAA compliant and secure virtual remote scribe which allows us to complete our medical charts more quickly and efficiently and focus more on you. If you have any questions about our remote scribe, please let us know.

Medical Appointment Cancellation/ No Show Policy:

Thank you for trusting your medical care to ADAPS Healthcare. When you schedule an appointment, we set aside enough time to provide you with the highest quality care. We understand there may be times when an unforeseen emergency occurs, and you might not be able to keep your scheduled appointment. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment cancellation/ no show policy below:

-Any established patient who fails to show or cancel/ reschedule an appointment and has not contacted our office with at least 24 hours notice will be considered a no show in charged a \$40 fee

-Any established patient who fails to show or cancel/ reschedule an appointment within 24 hours notice a second time will be charged an \$80.00 fee

-If a third no show or cancellation/ reschedule without a 24 hour notice should occur, the patient may be discharged from our practice.

-Any new patient who fails to show for their initial visit will not be rescheduled.

-The fee is charged to the patient, not to the insurance company, and will be automatically collected on the day of the no show, utilizing the credit card on file (see below).

-As a courtesy, we send out reminder emails, texts and occasional calls. If you do not receive a reminder, call or message, the above policy will still remain in effect as it is your responsibility to remember your appointment times.

If you should experience extenuating circumstances, please contact our office and speak with our Office Manager who may be able to waive the no show fee. You may contact the office during our regular business hours or leave a message after hours at 781-829-3300.

Credit Card Authorization:

Effective April 1, 2025 ADAPS healthcare requires a credit card on file. This is an explanation of when the credit card will be used. Your signature below indicates that you authorized the usage as detailed below.

Your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for your visit, you will be responsible for certain parts of the bill such as deductible,



co-insurance and copay. In addition, if you do not provide us with the correct information to process your claim, such as your insurance card, and the claim is denied, you will be responsible for these charges as well. According to your insurance plan, we are required to collect your copays, deductibles, and/or coinsurance. In providing the credit card information below you authorize payment for services rendered, including copays, co-insurance, deductibles, and or uncovered services.

Once your insurance settles the claim and notifies us of your patient responsibility, balances under \$200 will be charged AUTOMATICALLY. "NO SHOW" Fees will also be charged automatically.

For patient balances exceeding \$200, you will be notified by us prior to your credit card being charged.

A receipt for the amount charged will be automatically mailed to your home.

The security of your personal information is of the utmost importance to us. As such we use encrypted software to store your credit card information period to store your information into encryption you will need to swipe your card. As a result of this swipe you may see a charge for 0.1 cent on your account. In the event that your card is charged, we will place a one cent credit on your account which can be applied to future balance. Alternatively, you can ask us for a cash refund of the one cent presenting us a copy of the charge.

By signing below you acknowledge that you have read the no show policy/credit card policy above, you understand its terms and you accept full responsibility for all services rendered.

I have carefully read and fully understand this policy and have had all my questions answered.

Signature:	Legal representative/guardian signature:
Date:	Relationship to patient: