FAMILY RENEWED
Dawn M. Porter, MD

Patient Last Name, First Initial and DOB

CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS

Welcome to Family Renewed, LLC and thank you for choosing us for your family's mental health needs! We are committed to giving you the best possible care and service. To acquaint you further with our policies and procedures, we are providing you with the following information. Please take a few moments to carefully read this information before signing at the bottom of each page and complete the New Patient Registration form which also includes your insurance company name, subscriber name and date of birth, etc. if we are billing insurance on your behalf.

Appointments: Your time is valuable – and so is Dr. Porter's. If you need to cancel an appointment, please contact the clinic at least 24 hours in advance between the hours of 8:30am and 5:00pm so that we can offer your time slot to another patient. If you do not call and cancel your appointment during that time, you will be charged a **late cancellation/no show fee of at least $35/$50(F/U) or $50/$75 (New) respectively per missed appointment that must be paid prior to being seen for next appointment.** Please note that Dr. Porter does reserve the right to terminate services or deny assistance to any patient who uses abusive, profane or threatening language or engages in an unprofessional manner, does not comply with roles and responsibilities of clinic or engages in therapeutic conflicts with Dr. Porter.

Messages and Medication Refills: Please note that Dr. Porter is not in the office every day, however, calls are answered daily during the business hours of 8:30am-5:00pm. Dr. Porter is not available on weekends. If you have an emergency, please see the emergency section below. If you need to speak with Dr. Porter for medication refills or other non-emergent issues, please call the office at (314) 238-7240 and she will return your call within 48hours during weekdays. With regards to refills, please call the clinic at least seven business days before a refill is needed to assure your child does not run out of medication. Dr. Porter provides enough medication to last until your next scheduled appointment. If you should miss your next appointment or need to cancel/reschedule for some reason, Dr. Porter will call in a non-controlled substance Rx to your preferred pharmacy with enough medication to last until your next scheduled appointment.

Emergencies: For urgent issues, you may contact Dr. Porter at (913) 461-0369, her practice cell phone. In case of an after hour emergency, please keep you, your child or your family safe and go to the nearest emergency room or dial '911' for help. You may also contact the national suicide prevention lifeline at 1-800-273-8255 (TALK) which is a 24 hour, 7 day a week, toll free, confidential suicide prevention hotline, available to anyone in suicidal crisis or emotional distress.

I have read and understand all the above information, agree to the terms/conditions set herein, and consent to receive treatment at Dawn M. Porter, MD of Family Renewed, LLC.

Client/Guardian Signature **Date**

1670 Essex Way, Suite A101, O'Fallon, IL 62269
3636 S. Geyer Road, Suite 100, St. Louis, MO 63127
Phone: (314) 238-7240·Fax: (877)300-4369·www.familyrenewed.com

CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

Financial Responsibility: You are fully responsible for payment of all services provided to you and/or your child. Full payment is expected at the time of service, unless prior arrangements have been made. The adult accompanying the minor is responsible for payments at time of service. Unaccompanied minors will be denied non-emergency service unless charges have been pre-authorized through an approved plan or payment is made at the time of service.

Please make all checks payable to "Dawn M. Porter, MD." We also offer payment via cash, credit and debit cards. Please see the front office staff if you have any questions. Payments made by cash must be made in **exact change** as no cash money is kept on site. If any payments are made by check and returned as "non-sufficient," your account will be billed a $50 charge for banking fees and re-processing of your claim. At any time, if you have questions about your billing, please call our office staff at (314) 238-7240. We are only able to discuss your account with you, your guarantor, or your insurance company due to medical privacy laws. **Should your account become delinquent beyond 30 days, you will no longer be able to schedule an appointment or receive prescription refills.** If any of these financial procedures present a problem for you or your treatment, please discuss your concerns with Dr. Porter.

Please feel free to contact the office to obtain information regarding self-pay and simple pay schedules. At this time, Dr. Porter only accepts Tricare/Health Midwest, Cigna and Blue Cross/Blue Shield of IL and MO for children, adolescents and young adults until the age of 21. If you do not have either of these insurance plans, you will be responsible for the full payment. Dr. Porter will provide you with a copy of your "paid in full" bill which will include the necessary documentation for you to file for out-of-network reimbursement (as permitted) with your insurance company. Only in special circumstances will patients over the age of 21 be accepted and those patients will be required to utilize the self-pay/simple pay schedule. "Additional" fees (not covered by insurance) may be required for formal reports or documents that need to be completed by Family Renewed, LLC, appointments scheduled outside of normal business hours at the request of the patient and No Show or Late Cancellation Fees. **Insurance co-pays, co- insurance payments and "additional fees" must be paid at the time of service in order to schedule a follow-up appointment.** We recommend that everyone obtain preauthorization referrals from their insurance companies and that you understand your insurance plan benefits, including any deductibles, and suggest that you make sure your referrals are active and always up to date. Please note, if your insurance provider changes during the course of your treatment, you will need to contact our clinic so we can discuss which fees will and will not be covered, otherwise, significant out-of-pocket expenses may occur.

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CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

Court Ordered Assessments: Court Ordered Evaluation Services can be contracted on a separate and distinct fee schedule based on an hourly rate. Because of the non-confidentiality nature of the evaluation, it is not conducive for a therapeutic engagement or treatment and the service is only offered as a discreet engagement of time to complete the evaluation. This service is self-pay only and is non-billable to your insurance company.

Confidentiality: Your patient records are the property of Family Renewed, LLC and are treated as confidential. Your records will not be released without your executed written consent, unless special circumstances arise, e.g., court ordered, etc. However, please know that we are also obligated to release certain information to get claims processed by your insurance company.

Contact Information: It is vital that you keep your contact information up-to-date with our office. If any of your information changes, please let us know so we can update your records. This would include any changes to your surname, address, home/cell/work phone numbers, marital status, employer/school, emergency contact information, primary care physician, and/or financial responsible party (Guarantor of your account balances). Without up-to-date information, we may be unable to contact you to confirm, reschedule or cancel an appointment due to illness, inclement weather, etc., file your insurance claims properly, or refill your prescriptions.

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CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

NO SHOW/LATE CANCELLATION POLICY

Patient (please print):_____ Birthdate:_____

I UNDERSTAND THAT I MUST GIVE **24 HOURS** ADVANCE NOTICE DURING REGULAR BUSINESS HOURS IF I OR MY CHILD IS UNABLE TO KEEP HIS/HER SCHEDULED APPOINTMENT.

APPOINTMENT TYPE	**Initial (New)**	**Follow-Up (FU)**
NO SHOW FEE (Not billed to Insurance)	**$75**	**$50**
LATE CANCELLATION FEE (Not billed to Insurance)	**$50**	**$35**

I understand and acknowledge the 24 hour cancellation/ No Show policy: ☐ **YES** ☐ **NO**

We appreciate your efforts in keeping your appointments or canceling them within 24 hours so that we are able to offer this time to another patient that may be waiting for an immediate appointment.

Thank you.

_____
Patient Name Date

_____
Parent/Guardian (please print): Date

_____
Parent/Guardian Signature Date

_____
Witness Date

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CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

HIPPA ACKNOWLEDGMENT

Patient (please print):_____ Birthdate:_____

Parent/Guardian, authorized person (or patient if minor has turned 18 during the course of service) must initial in the space provided ( ) prior to any treatment being rendered or continued.

PRIVACY POLICY: I hereby acknowledge receipt of the "Notice of Privacy Practice/Policies" of Dawn M. Porter, MD of Family Renewed, LLC. I have reviewed the documents on the date indicated below. I understand the limits of confidentiality, privacy policies, my rights and their meanings and ramifications. I further acknowledge that if I have any questions about this notice, I may contact Dawn M. Porter, MD of Family Renewed, LLC. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Dawn M. Porter, MD of Family Renewed, LLC. I further authorize Dawn M. Porter, MD of Family Renewed, LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Dawn M. Porter, MD of Family Renewed, LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____)

_____

Patient/Parent/Guardian (please print): Date

_____

Patient/Parent/Guardian Signature Date

_____

Witness Date

Parent/Guardian Signature Date

_____

Witness Date

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CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

Authorization for Release of Health Information between Dawn M. Porter, MD and our Primary Care Physician.

I, _____, request that health information regarding my or my child's care and treatment be released to/from Dawn M. Porter, MD of Family Renewed, LLC, of Illinois or Missouri, as set forth on this form.

I further acknowledge that I understand that this authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS RELATED INFORMATION only if I place my initials on the appropriate line in item 5.

In the event the health information described below includes any of these types of information mentioned above, I will initial the space on the appropriate line in item 5, and specifically authorize release of such information between Dawn M. Porter, MD of Family Renewed, LLC and my or my child's primary care physician listed on line 3.

1. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 3. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

2. Signing this authorization is voluntary. I understand that generally my treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

3. Name, Address and Phone of Person(s) to/from whom this information will be disclosed:

_____

_____

_____

4. Purpose for Release of Information:

_____

_____

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CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

Authorization for Release of Health Information between Dawn M. Porter, MD and our Primary Care Physician.

5. Unless previously revoked by me, the specific information below may be disclosed for a period of one year from today's date unless specified here.

From: _____ (start date) until _____ (expiration date).

All health information (written and oral may be released between the parties specified above), except:

_____

For the following to be included in the release, indicate the specific information to be disclosed and initial in the space provided.

_____ Mental Health Clinical records/information
_____ Records from alcohol/drug treatment programs
_____ HIV/AIDS related information to be disclosed

6. All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT (If patient is 13 years or older) DATE

_____ _____
SIGNATURE OF GUARDIAN (include relationship) DATE

_____ _____
SIGNATURE OF WITNESS DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

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CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

AUTHORIZATION FOR RELEASE OF MEDICATION HEALTH INFORMATION

I, or my authorized representative, request that health information regarding my care and treatment as it related to my medications be released as set forth on this form:

In accordance with **Illinois and Missouri** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. Dawn M. Porter, MD of Family Renewed, LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to Dawn M. Porter, MD of Family Renewed, LLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Dawn M. Porter, MD of Family Renewed, LLC.
3. I have the right to revoke this authorization at any time by writing to Dawn M. Porter, MD of Family Renewed, LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE DAWN M. PORTER, MD OF FAMILY RENEWED, LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____

Patient/Parent/Guardian Signature Date

_____

Patient/Parent/Guardian Signature Date

_____

Witness Date

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CLIENT AGREEMENTS AND ACKNOWLEDGEMENTS (cont.)

CHILD AND ADOLESCENT CONSENT FOR TREATMENT

Patient (please print):_____ Birthdate:_____

I certify that I am the (check one) ☐ father, ☐ mother, ☐ legal guardian of the above named child/adolescent and that I do have legal custody of or authority over the above named child/adolescent. I hereby give my consent to the treatment of my minor child, adolescent and/or my family as indicated/recommended and provided by Dawn M. Porter, MD of Family Renewed, LLC. I further authorize the services deemed necessary or advisable by Dr. Porter to address the needs of my child/family (legal custodial documentation to be provided if indicated)

_____

Parent/Guardian (please print): Date

_____

Parent/Guardian Signature Date

_____

Witness Date

DIVORCE/LEGAL SEPARATION COLLECTION POLICY

It is the policy of Dawn M. Porter, MD of Family Renewed, LLC, that the parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. You will be responsible for payment of the child's/adolescent's treatment regardless of any financial arrangement for payment of the child's/adolescent's medical care, either oral or written, with the child's/adolescent's other parent or responsible party. Dawn M. Porter, MD of Family Renewed, LLC assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for your child's/adolescent's medical care.

I have read and understood the above policy and agree to the terms and conditions:

_____

Parent/Guardian (1) (please print): Date

_____

Parent/Guardian (2) Signature Date

_____

Witness Date

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