



Patient Demographic Information Form

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: [] Male [] Female [] Other

Address: _____

City: _____ State: _____ ZIP: _____

Phone (Home): _____ Phone (Cell): _____

Email Address: _____

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Referring Provider: _____

Address: _____

Phone: _____ Fax: _____

Primary Care Provider: _____

Address: _____

Phone: _____ Fax: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone (Home): _____ Phone (Cell): _____

Name: _____ Relationship: _____

Phone (Home): _____ Phone (Cell): _____



PA PRIVACY NOTICE FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

1. The Privacy Notice includes a complete description of the use and /or disclosures of my personal health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: calling my home and leaving a message on my answering machine or with the individual answering the phone and text messages.

4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for the treatment, and necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, it is binding on the Practice.

6. I understand that this Consent is valid and that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

9. The privacy Notice of MD TruCare PA (the “practice”) has been provided to me prior to signing this consent. The practice has explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent. I have read and understood the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

DATE

Signature of Patient/ Guardian



FINANCIAL POLICY

Copayments and Deductibles All copayments and deductibles will be collected on the day of your appointment, as you check in. All Insurance companies require that physicians collect all co-pays/ deductibles from the patient at the time of service. The arrangement is also part of your contract with your insurance company. We accept payment in the form of cash, check, CareNow debit or credit card. If you are unable to pay your copay, the office of MD TruCare will hold the right to postpone future office visits, until outstanding balances are paid.

Insurance We are contracted providers for most insurance plans. If you are insured by a plan we do business with, payment in full is mandatory at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance coverage should change, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Claim Submission We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance for your claim is your responsibility whether or not your insurance company pays for your claim. If your insurance company does not pay your claim after 120 days after your date of service, the balance will automatically be billed to you. **Non-Payment** If your account is over 90 days past due, you will receive a letter stating you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated.

Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you will be discharged from this practice.

As acknowledged by my signature below, I understand the payment policies of MD TruCare and I also understand that I am financially responsible for all charges incurred regardless of insurance coverage. If the balance on my account is not paid, I agree to bear all interest charges and collection costs.

I also authorize the release of limited medical information to my insurance company, as required for payment of charges and authorized payment of insurance benefits directly to MD TruCare PA for all services rendered.

Patient Signature

Date



MEDICATION REFILLS POLICY

The following policies are designed to improve the efficiency of the office and communication between you and the staff of MD TruCare. Please read, initial each statement and sign at the bottom of the page to indicate your understanding of the policies.

It is your responsibility to fill your prescription before you run out of medications, and to protect your medications and controlled substances as carefully as you would your money or jewelry. Your pharmacy may not allow refills prior to the prescribed date. Our office does not accept refill requests from the pharmacy itself. _____ (initial)

MDTruCare does not prescribe controlled medications (medication with high abuse potential) for patients with a history of substance abuse, particularly those that the patient has already abused. Also, we do not refill lost, misplaced, stolen or otherwise unavailable controlled medication except under specific circumstances. Repetitive requests of this nature may be declined. It is your responsibility to fill your prescription before it expires. _____ (initial)

Reasons such as:

1. "I went up on the dose on my own."
2. "I went out of town and left my medication behind when I returned home."
3. "The airlines lost my luggage which contained my medications."
4. "My spouse/roommate/girl or boy/friend/son/daughter/pet etc... stole my medication."
5. "I gave a few pills to my spouse/significant other because he or she needed them."
6. "I opened my medication above the sink/ toilet/ pool/ lake..... and it fell in."

are **Not** valid reasons for early refills of medication, so please do not ask. In the event your medication is stolen, we do require a police report prior to submission of the refill.

(initial)

Per CDC guideline, refills of prescriptions require periodic office visits with the doctor. It is important to comply with your scheduled doctor's visit to have a successful treatment plan. Standard medication management and follow-up is every 2 to 4 weeks or otherwise specified. Schedule visits must be followed in order for the prescription(s) to be filled. Please see attached clinic fees list for requesting a refill without an appointment. _____ (initial)

Printed Name

Patient/Guardian Signature

Date: _____



No Show Policy Acknowledgement Form & other fees not covered by insurance

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELED APPOINTMENT

I understand and agree to the following terms:

1. It is my responsibility to notify MD TruCare PA if I need to cancel or reschedule a scheduled appointment no less than 24 business hours prior to the scheduled appointment.
2. I hereby agree that I will be billed by my provider **\$75** in the event that I miss an appointment.
3. Fee for medical records request will depend on the number of pages and delivery format. Paper copies are **\$25** for the first 20 pages, and **0.50** cents per page after that. Electronic Fax delivery is **\$25** for 500 pages or less, and **\$50** for anything in excess of 500 pages. Faxing medical records to another clinic for continuation of care is free of charge with a PHI form filled out allowing us to legally do so. Records placed at the front desk for pick up will be held for up to 30 days before shredding.
4. Fee for letter of Accommodations for school or for Employers, Etc is **\$30**
5. Telephone calls (Consultation) **\$30** for 15 minutes
6. A letter for a legal office/attorney is **\$15**
7. There will also be a **\$20** charge for some non-office visit refills of **Schedule II Controlled Substance (ex. Adderall, Ritalin etc.)** when you are calling in for a refill. This payment **must** be obtained before sending out your prescription and this can be done via phone, email, or in person. Missing or canceling/rescheduling your upcoming appointments after receiving your refill will require your next visit to be in office. You may request to be seen in accordance with your refill schedule to avoid this fee.
8. Please note that there will be a fee of **\$50** for any bounced check as the bank takes a processing fee.
9. **I understand that these fees are non-covered in-office services and may not be billed to my insurance carrier.**

Acknowledgement by Patient (Signature)

Date



Disability/FMLA Paperwork Consent

Effective immediately as per practice policy, any new patient requests for Disability/FMLA paperwork require that the patient will be seen at the clinic for a minimum of 3 visits. It is under the provider's discretion to determine if the patient qualifies for disability regarding current psychiatric conditions. This does not guarantee that the patient's employer will approve the claim. All disability/FMLA paperwork is billed to the patient and not their insurance as an in office fee of \$150. This fee will be due again if renewal is required after 6 months. Payment will be required in full prior to the paperwork being completed.

Thank you for your participation

Acknowledgement/Signature of Patient

Date



Clinic Fees

Insured- New Patient appointment(collected at time of booking): **\$100**

Self-Pay New Patient appointment (collect at time of booking): **\$350**

Self Pay Follow-up Appointment: **\$150**

Rx Refill Administrative Fee:(if getting refill of a controlled medication without an appointment)
\$20

FMLA Forms: **\$150** (this covers all services with this form for 6 months)

Medical Records: Fee for medical records request will depend on the number of pages and delivery format. Paper copies are **\$25** for the first 20 pages, and **0.50** cents per page after that. Electronic Fax delivery is **\$25** for 500 pages or less, and **\$50** for anything in excess of 500 pages. Faxing medical records to another clinic for continuation of care is free of charge with a PHI form filled out allowing us to legally do so.

No-Show/Cancellation/Reschedule of follow ups: (within 24 business hours of appointment) **\$75**

No-Show/Cancellation/Reschedule of New Patient (within 24 business hours of appointment): results in loss of **\$100.00** deposit taken at time of scheduling.

*No-showing/canceling/ rescheduling a NEW visit 3 consecutive times will result in being discharged from the practice. We do require patients to be seen in the office periodically to get updated vitals.

UDS-Urine Drug Screen: **\$35**

Please note that there will be a fee of **\$50** for any bounced check as the bank takes a processing fee

A visit may not be switched to telehealth without the providers approval. The above mentioned fees are in office charges that may not be billed to your insurance.

Patient/Guardian Signature

Date



AI Transcription for Medical Notes Notice

At MDTruCare, as part of our ongoing efforts to enhance the accuracy and efficiency of your healthcare experience, we employ cutting-edge technology, including artificial intelligence (AI) software, for the transcription of medical notes during your visits.

Our HIPAA-compliant AI transcription software assists our providers in documenting your medical history, examination findings, and treatment plans with precision and speed, ensuring access to comprehensive and up-to-date information. This leads to more accurate diagnoses and tailored treatment recommendations.

We want to assure you that the use of AI for transcription purposes is solely intended to improve the quality of care we provide. The notes generated by the AI software are securely stored within our internal systems and are accessible only to authorized personnel within MDTruCare. We do not sell or distribute these notes to any external parties, and the information remains confidential within the confines of our practice. To ensure your privacy and uphold the highest standards of data security we have implemented robust safeguards to protect your sensitive information.

If you have any concerns or questions regarding the use of AI in our medical practice, please feel free to reach out to our dedicated staff, who will be more than happy to provide you with further information.

Thank you for entrusting MDTruCare with your healthcare needs. We are dedicated to utilizing innovative technologies responsibly to deliver the best possible care for you.



PATIENT PORTAL

Please use your desktop or laptop to connect via patient portal. Click the link below and log in to your patient portal.

<https://mycw120.ecwcloud.com/portal16529/jsp/login.jsp>

****If the above doesn't work, please see the following steps.***

PORTAL INSTRUCTIONS

On a PC

Go MDTrucare.com

Click the "**Patient Portal**" tab on the (should be top right, it's a light orange color)

Sign in using phone number on file

Input and confirm DOB, Name, and phone number

It should send you a code to your phone on file

Input the code where requested.

Complete the Captcha if necessary

Practice Code is AJHDBD

MOBILE LOG IN

If you attempt to log in, select "**Having trouble logging in**", then "**forgot password**"

Once again confirm your information.

Your username is the email on file.

It will email you instructions for resetting/creating your password.

The practice code is the same. **AJHDBD**