Updated Shared Electronic Medical Records

We share an electronic medical records system with Community Medical Centers.

Smoke-Free Environment

For the health and safety of our patients, the University Centers of Excellence has a No-Smoking policy including, but not limited to, the use of tobacco products, vaping devices, pipes, and chewing tobacco.

Weapon-Free Environment

Weapons of any kind are not allowed at any of the University Centers of Excellence faculty practice sites.

Pet-Free Environment

For the health and safety of our patients, the University Centers of Excellence has a No-Pets policy. **This No-Pet policy applies to pets, emotional support animals, comfort animals and therapy animals.** University Centers of Excellence complies with the Americans with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, we do allow working service dogs to accompany our patients. Service animals are individually trained to perform work or tasks for people with disabilities. Service animals are required to be leashed or harnessed except when performing work or tasks where such tethering would interfere with the dog's ability to perform the work or tasks.

Consent to Photograph

This form is to be used only for photographs taken for treatment or any University Centers of Excellence own health care operations. Photography for other purposes (e.g., research, publication, outside education,marketing, public relations, news or documentary) requires use of another form "Authorization for Use and Disclosure of Photograph, Video Interview, or Likeness".

I, the undersigned, hereby consents to be photographed while receiving treatment at the office, with the understanding that the images from such photography may be used for my treatment or for office health care operations such as peer review or medical education, as the office Medical Director and/or my treating physician deems appropriate, and that such use is subject only to the following limitations:

The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

____ ____________________

Patient Signature (Guarantor if patient is a minor) Date

____

Print Name

No Show/Appointment Cancellation Policy

We would like to provide you with outstanding service. This however requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient. If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a "No Show" and a $35.00 charge may be billed directly to you since it is not covered by any insurance plan.

I have read, understand, and agree to the above No Show/Appointment Cancellation Policy.

____ ____________________

Patient Signature (Guarantor if patient is a minor) Date

____

Print Name

Electronic Communication Exchange Consent

We offer electronic communication services via text messaging, email, and voice messaging to serve you better.

Electronic communication is used for but not limited to:

- Appointment Reminders
- Patient Surveys
- General Health Tips

____ I want to receive electronic communication exchange services.

____ I do not want to receive electronic communication exchange services.

Patient Signature (Guarantor if patient is a minor) ____________________ Date ____________________

Open Payments Database Notice

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at **https://openpaymentsdata.cms.gov.**

Patient Signature (Guarantor if patient is a minor) ____________________ Date ____________________

Agreement and Authorization for Services Consent Form

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to University Centers of Excellence, also known as Central California Faculty Medical Group and University Faculty Associates, that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the University Centers of Excellence medical staff and personnel. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination.

II. Retention of Information

I understand that University Centers of Excellence may record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by University Centers of Excellence for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-University Centers of Excellence personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

III. Release of Information

I hereby authorize University Centers of Excellence to release to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, its insurance carriers or intermediaries any medical records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by University Centers of Excellence and the physicians associated with it. I may revoke my consent at any time for any reason by providing written notification to University Centers of Excellence. This authorization shall not conflict with any internal University Centers of Excellence policy regarding release of information which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal Law.

IV. Teaching Program

University Centers of Excellence are affiliated with the University of California, San Francisco School of Medicine (UCSF). UCSF is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary healthcare professions, post-graduate fellows and other trainees may observe, examine, treat and participate, at the request and under the supervision of the attending physician in the patient's care, as part of UCSF's medical education programs.

V. Assignment of Benefits and Guarantee of Payment

In consideration of University Centers of Excellence and medical services provided to me, I hereby assign University Centers of Excellence and physicians and other professionals associated with University Centers of Excellence all of my rights and claims for reimbursement under Medicare, Medicaid, or group accident or health insurance policy for which benefits may be available for payment of the services provided. I agree to pay University Centers of Excellence and the physicians and other professionals associated with University Centers of Excellence the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.

I have read each of the foregoing, I-V and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

Patient	Date
Guardian if patient is under 18 years old	Date
Other (record relationship to patient)	Date
Witness	Date

Financial and Billing Policies

Thank you for choosing the physicians at Central California Faculty Medical Group, University Faculty Associates and University Centers of Excellence (UCOE). We are committed to clinical excellence in meeting your health care needs. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. If you have any questions, call your health plan's member services department their number is listed in your benefit plan booklet or on your ID card.

- **Inform Us of Changes:** If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and responsibility for the cost of the entire visit.
- **Bring Your Health Information:** Bring your health insurance information to your visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly additional forms depending on your visit.
- **Co-Payments, Deductibles and Co-Insurance:** Co-pay's are due at time of your office visit. Under the terms of our contract with the various insurance plans we cannot waive any co-payments, deductibles or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience we accept cash, checks, debit, VISA, and MasterCard.
- **Patient Responsibility Balances:** All patient responsible balances must be paid in full or a financial arrangement must be made at the time of your visit.
- **Deposits:** For certain procedures, you may be required to pay a deposit or pay for the service in full prior to treatment.
- **Prompt Payment:** We offer a prompt payment discount. Please contact our Billing Department for details.
- **Prior Authorization:** Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre existing, or is not a covered service you will be asked to pay prior to the time of service.
- **HMO/Managed Care Plans:** It is your responsibility to make sure a current referral has been obtained for your care with our providers. If a referral has not been obtained by your appointment you may need to reschedule your visit until you have a current referral. We realize this is an inconvenience, but without the referral our physician will not be reimbursed for the services provided.
- **Workers Compensation:** Please bring your claim number, date of injury and employer/workers compensation information. Your claim needs to be open and valid for the condition that we are seeing you for.
- **Statements:** You will not receive a statement until your primary insurance company has fulfilled its financial responsibility or a service is determined to be patient responsibility.
- **Who Can Discuss a Bill:** Confidentiality is important. Our Patient Account Representatives may only speak with the patient or the person designated in writing by the patient to receive the bill(s) on behalf of the patient.

All billing inquiries are handled by our billing staff. If you should have any questions regarding your bill or the status of your account please contact our office at: 559-453-5231, Monday through Friday 8:00 am – 4:30 pm.

Continued on next page

Financial and Billing Policies - continued

I have read, understand, and agree to the above Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to University Centers of Excellence. I authorize University Centers of Excellence to release pertinent medical information to my insurance company when requested, needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform University Centers of Excellence of any changes regarding my personal billing information or my insurance billing information.

____ ____________________

Patient Signature (Guarantor if patient is a minor) Date

Central California Faculty Medical Group (CCFMG) and University Centers of Excellence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Your provider may be a member for the Community Foundation Medical Group. That means that billing statements for services provided by your physician will come from and be processed by Community Foundation Medical Group and/or Central California Faculty Medical Group.

Notice of Your Right to Receive a "Good Faith Estimate"

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 559-453-5240.

Your Rights and Protections Against Surprise Medical Bills

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What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing". This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care-like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services: If you have an emergency medical condition and get emergency services from an out-of network provider or facility, the most the provider or facility may bill you is your plan's in network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

California law protects you from surprise medical bills when you go to an in-network health facility and receive care from an out-of-network provider without your consent. You will only have to pay your in-network cost sharing in that circumstance. Medical providers now cannot send you out-of-network bills when you follow your health insurer's requirements and go to an in-network facility.

Certain services at an in-network hospital or ambulatory surgical center: When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon; hospitalist, or intensivist. These providers can't balance bill you and may not ask you to give up your protections not to be balanced billed.

If you get other services at these in-network facilities, out of network providers cant balance bill you, unless you give written consent and give up your protections

You're never required to give up your protections for balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plans network.

California law protects you from surprise medical bills when you go to an in-network health facility and receive care from an out-of-network provider without your consent. You will only have to pay your in-network cost sharing in that circumstance. Medical providers now cannot send you out-of-network bills when you follow your health insurer's requirements and go to an in-network facility.

Continued on next page

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the co-payments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

California Department of Insurance 1-800-927-4357 or **https://cadiapps.insurance.ca.gov**

California Department of Managed Care – 1-888-466-2219 or **https://dmhc.ca.gov**

Visit **https://www.cms.gov/nosurprises/consumer-protections** for more information about your rights under **Federal Laws**

Visit **http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/AB-72-Fact-Sheet-Consumer_Protection_for_Surprise_Medical_Bills-rev2.pdf** for more information about your rights under **State Laws**

Acknowledgement of Receipt of Privacy Notice

I have received the University Centers of Excellence Privacy Notice during this visit. I understand that I may obtain a copy of any future revised Notices at any University Centers of Excellence location or on University Centers of Excellence website: UniversityMDs.com.

____ ____________________

Patient/ Spouse/Nearest Relative/Legal Guardian Date

To be completed by University Centers of Excellence Employee if acknowledgement is not signed:

Reason that this acknowledgement was not signed:

- ________ Patient indicates received on prior visit
- ________ Patient declined to sign
- ________ Other

____ ____________________

Patient/Representative initials if declined Employee’s initials

Personal Representative

In the space below, if so desired, please indicate any personal representatives*/individuals who are permitted to receive or know information concerning your healthcare for the period 12 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact CCFMG in writing and request the change.

Name(s):____

____

____ ____________________

Patient Signature Date

**A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is any family member, friend or individual designated by the patient to whom the patient’s health information may be disclosed.*

Central California Faculty Medical Group (CCFMG) and University Centers of Excellence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin,age, disability, or sex.