MB CARE PC

30 Controls Dr., #10, Shelton, CT 06848
P: 203-864-5031 / F: 203 549 0890

PATIENT TREATMENT AGREEMENT

I understand that this Agreement is essential to the trust & confidence necessary in a physician/patient relationship and that my physician undertakes treatment based on this agreement.
I understand that if I breach this agreement my physician will stop prescribing controlled substances.
I will not share, sell or trade my medication with anyone.
I understand that my medications are my responsibility; I will safeguard my medication from "loss" or "theft".
I understand that **lost or stolen medications will not be replaced under any circumstances.**

I understand that such mishandling of my medications is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

I understand that refills of **controlled substances** will be made only at the time of an office appointment during normal business hours. Refills for controlled medication will not be made over the phone. You must come to the office for an appointment. Narcotics prescriptions will not be written for more than 30 days. Should you receive another narcotic prescription from another prescriber, you need to inform us. Failure to do so may result in your dismissal from our practice.
We will do our best effort to respond for refills requested on weekends.
I agree to take my medication exactly as prescribed so as to not run out of medication.

I understand that use of my medication at a greater rate will result in my being without medication for a period of time. **Our office does not provide early refills for medications;** any medication changes must be approved by the doctor.

I agree to adhere to the payment policy outlined by this office (see page 2).

I agree to conduct myself in a *courteous manner at all times* when in the doctor's office.
Inappropriate language or behavior towards administrative or clinical staff will not be tolerated.

I agree to provide random urine samples for drug testing at Dr. Boran's request. I understand that positive results except from prescribed medication may result in termination of care.

I will not hold responsible MB Care, Dr. Boran and staff members for any inadvertent event resulting from my misuse of all prescribed medication.

I understand that violation of the above may be grounds for termination from this practice.
MB CARE will make all notifications of termination of care in writing.

_____ _____

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PATIENT SIGNATURE DATE

PAYMENT POLICY

I hereby authorize the release of pertinent medical information to my insurance carriers for the purpose of treatment and payment. I am aware that health insurance coverage varies and while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by MB CARE PC and any other charges as a result of the treatment rendered. If I have insurance that Dr. Boran is contracted with, I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any services that are not considered medically necessary by my insurance company.

I understand and agree that if I fail to keep my scheduled appointment and I do not give at least 24-hour notice of cancellation I will be charged for the scheduled time.
The missed appointment charge will be $50.00.
I understand that I am solely responsible for this missed appointment fee and that it will not be billed to my insurance.

Copayment is due at the time of the appointment.

To avoid unnecessary invoicing, please notify us if you have any changes in your insurance coverage.

We do not complete FMLA, SSD, Psychiatric evaluation or Court related forms.

In the event that I fail to pay the balance or fail to set up a payment plan of my account to MB CARE PC within ninety (90) days of the date of service, my account may be turned to collection. In the event that it is necessary to turn my account over to collection I understand that I will also be responsible for any and all costs of collection, including attorney fees and interest charges.

Our cash rates (which may be different than the contracted rate we have with your insurance company) are as follows:

- Initial Assessment: $200
- Medication management and individual therapy - 20 minutes session: $100
- Medication management and family therapy – 20-30 minutes session: $150

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NOTICE OF PRIVACY PRACTIVES

MB CARE PC is required by Federal Law to maintain the privacy of your health information and that you be provided with this Notice of our legal duties regarding our privacy practices. You are referred to the attached Notice of Privacy Practices that contains all the elements of MB CARE's privacy practices. The "Notice of Privacy Practices" explains how MB CARE PC protects and uses your personal health information, and your rights pertaining to your health information when, and after, you receive care at MB CARE.
MB CARE may change its Notice of Privacy Practices at any time. In addition to being provided to you with this paper copy, our current Notice of Privacy Practices will be displayed on our web site [www.mbcarepc.com].

How We Collect Information About You: MB CARE PC and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, via text, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between MB CARE PC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance.

Uses and Disclosure of Protected Health Information May Be Made for Treatment, Payment, Healthcare Operations and Other Purposes Without Prior Authorization.

Unless you disagree, we may contact you for appointment reminders or to tell you about possible treatment choices, health benefits or services.

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Unless you disagree, we may disclose medical information about you to a friend or family member who is involved in your medical care, or to a disaster relief authority so your family may be notified of your location and condition.

Subject to certain requirements, we may give out health information about you without your authorization for public health purposes, abuse or neglect reporting, audits or inspections, research studies, required notifications of death, Worker's Compensation, the Food and Drug Administration, health oversight, judicial and administrative proceedings, law enforcement, specialized government functions, state surveyors, licensing, accrediting, quality oversight agencies, and emergencies.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of MB CARE. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

Your Rights Regarding Medical Information About You: You have the right to request a copy or view your medical information that we use to make a decision about your care. You may be charged a fee for the copies.

If you believe that your information in your record is incorrect or important information is missing, you have the right to request we amend the records.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

DOB: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office via email (mbcarepc@gmail.com) or online at www.mbcarepc.com (under Patient Forms).

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

HIPAA - ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (print your name), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations. I have also been shown the Privacy Policy for this Office, and have been offered a copy of such policy to keep for my records.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____