Montana
Headache Clinic

Financial, Consent to Treat, Authorizations, and Acknowledgements

Consent for Treatment: I do hereby request and authorize care from qualified personnel at the Montana Headache Clinic [MHC], including appropriately supervised students, treatment and procedures as may be necessary in accordance with the judgement of the medical practitioner. I acknowledge that no guarantee can be made by anyone concerning the results of treatment, examinations or procedures. **Treatment of Minor Children:** I understand minor children [less than 18 years old] must be accompanied by a parent or guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child are due at the time of service regardless of court-ordered responsibility.

Financial Agreement: In consideration of the Healthcare Services provided to me, and/or any individuals who I am directly responsible for medical bills, such as a parent, ward, or guardian, (collectively "Guarantor") agree to pay MHC billed charges related to those Healthcare Services ("charges") minus any contractual reductions from the Charges agreed to MHC with my Health Plan Payor (if applicable). I agree and understand that it is possible my Health Plan will determine that the services provided to me are not covered services and that I will be responsible for paying for those services.

Payment: Guarantors may make payments to Montana Headache Clinic, PLLC at the time the services are provided to me; in accordance with billing statements received; or in accordance with a payment arrangement schedule that is agreed upon by Montana Headache Clinic, PLLC and the Guarantor. If the Guarantor fails to make any scheduled payment when due, I understand and agree that MHC may declare the entire balance to be due immediately and/or Guarantor's account may be assigned to third party collection agency.

Overpayments: If my account is overpaid by less than $15.00, I agree that the amount is too small to refund, and that MHC may do any of the following: (1) apply the overpayment amount to any other outstanding balance that I have (2) apply the overpayment to future services (3) MHC may write off the overpayment amount. If my overpayment amount is over $15.00, MHC will attempt to contact me to refund the overpayment, only after all my claims have been paid by my Healthcare Payor.

Assignment of Benefits: Without wavier or limitation of the above Financial Agreement, I hereby (1) authorize MHC, on my behalf, to submit a claim for and to accept, negotiate and deposit payment from any Health Plan Payor, and other third-party providing coverage for, or who may be otherwise be liable for payment of any charges for the Healthcare Services provided to me (2) direct those Health Plan Payors and responsible third parties to make payment directly to MHC.

Patients with out of network insurance/Other Health Plan Payor/Health Share Product – I understand and agree that MHC may collect its charge from Guarantors when MHC does not have a written contractual agreement with an insurance company i.e. out-of-network. Out of network benefits will cost me more out of pocket expense. It is my responsibility to determine if my HCP is in network.

Medicaid: I acknowledge that MHC does not "back bill" claims to Medicaid. It is my responsibility to inform MHC of my Medicaid eligibility. (MCA 37.85.406 Para 11g). MHC will not refund payments that I paid for claims prior to the date of my eligibility. If my coverage lapses, the services rendered are my responsibility and by signing this document I agree to pay for the services provided.

Photograph/Video: I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property of MHC unless I withdraw my consent in writing. I understand and agree not to photograph, videotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

Consent for Virtual Health/Telehealth Services: I hereby consent to engage in virtual health or telemedicine services where available, as part of my treatment. I understand that this meeting format does not involve being in the same physical location. The transfer of data for this type of interactive visit incorporates network and software security protocols to protect the confidentiality of patient's identification and imaging data and includes measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Release of Responsibility for Personal Valuables: I am aware that MHC provides no facilities for safekeeping of valuables. I hereby release MHC from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to MHC, or facility.

Prescriptions: It is my responsibility to request refills 15 days prior to the end of the available refills. Refills will not be granted if I have not seen the provider within the prior six months. By signing this document, I am authorizing MHC to obtain my medication history from my pharmacy.

Prior authorizations services and/or medications: I hereby acknowledge PAs may take up to 30 days to obtain for prescriptions and diagnostic testing. This includes staff's time and my insurance processing time.

Binding Arbitration. I am aware that except as otherwise provided in this document, or required by law, all remaining disputes between me and MHC that have not been resolved through mediation will be submitted to final and binding arbitration instead of litigation.

Release of Information: I hereby acknowledge that MHC is by law authorized to release medical and account information necessary for the purposes of treatment, payment, and healthcare operations. This information may be released to Health Plan Payor, liability insurance companies, billing companies, collection agencies, consulting healthcare providers,
governmental programs or medical review organizations and otherwise as permitted or required by law. By signing this document, I authorize MHC to obtain my current and past medications and prescription history from my current and former pharmacies. Health Information Exchange. MHC may share information that is obtained or created about me with other health care providers or other health care entities, such as my health plan, as permitted by law through Health Information Exchanges (HIEs) in which they participate. For example, information about my past medical care, current medical conditions, and medications may be available through HIEs. Exchange of health information may provide faster access, and better coordination of care. I acknowledge that if I do not wish for me/ward's PHI to be released, I will request an OPT OUT form.

Release of information Continued: I understand that without ethical scientific research, many of the medications and medical procedures we have today would not be possible. Since a valid research design begins with participants that meet the criteria for the study, I hereby:

- ❒ Give Boeson Research access to my electronic medical record for the purpose of notifying me of studies I might be interested in entering.

- ❒ DO NOT give Boeson Research access to my electronic medical record.

Consent to Contact: I agree that for MHC to service my account, and collect any amounts I owe, MHC, business associates, account management companies. or collection agencies, may contact me by telephone, SMS text message, email, cellular, or residential telephone number I provided during my registration process. These methods of contact may include auto-dialed, prerecorded, or artificial voice messages or texts as permitted by law.

Forms: Due to the increased request for completing forms such as FMLA or driver's license forms, I acknowledge that I will need to make an appointment to discuss and complete any form during an allotted appointment time. I also acknowledge that MHC does not complete disability determination forms or become involved in disability determinations. I agree to pay $10 per page for documents completed outside an office visit.

Appointments: I acknowledge I am to arrive 10 minutes early for your appointment to allow time for paperwork and to update my information. **If I arrive five or more minutes after my scheduled appointment time, my appointment will be rescheduled.**

Discharge: Once established at MHC, my inability to maintain trust, respect, and responsibility could result in discharge. This may include but is not limited to failing to show for appointments, excessively rescheduling appointments, hostility toward providers or staff or lack of cooperation with the plan of care.

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Signature of patient or parent/Legal Guardian/Authorized Representative Date

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Printed of patient or parent/Legal Guardian/Authorized Representative

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