Office Policies Form

Late Arrival Policy :

- Arriving late to an appointment may result in visit being truncated to allow for others to be seen on time. A shortened visit may result in an incomplete assessment and need to return for further assessment.
- If late for the visit, you have missed your appointment, may not be seen, and will still be required to pay the reschedule fee.
- Multiple late cancellations or no-shows may result in dismissal from the practice.

Telemedicine Consultations :

- The doctor will sometimes engage in a telemedicine (video) consultation, for example during a public health emergency where it is safer to remain at home. The telemedicine consultation will not be the same as a direct office visit since I will not be in the same room as my doctor.
- The doctor assumes I am alone during our consultation, and she will not know if there are any other people in the same room as me, or within hearing distance, unless I say so, thus confidentiality may be breached if she discusses topics of a private nature.
- There are other potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. My doctor or I can discontinue the visit at any time if we so desire.
- As an alternative to a telemedicine consultation, I can cancel and reschedule my visit for a later time or seek care from another doctor’s office. If my doctor feels a direct physical examination or other testing are necessary, she will ask me to come in for another visit to complete any remaining tests.
- I and/or my insurance company will be billed for the visit in the same manner as regular office visits. My insurance company may or may not cover the visit in the same manner, though.

Telephone and Email Policy :

- I will be asked to schedule an appointment if issues or questions arise between scheduled appointment times. The best way to discuss my care is in a scheduled office visit to allow for examination, as necessary.

- There are inherent privacy concerns in communicating by email, and I will use the patient portal for any general, non-urgent questions. For more involved matters, I will schedule either an office visit or a telephone encounter.

Results, Forms, and Paperwork Policy :

- I agree to come to my follow-up appointments or schedule a telephone encounter so I can discuss the results of any of my results and what they mean to my care.
- Requesting paperwork and form completion is best done during my appointment.

Controlled Medications Policy :

- Dr. Howell does not prescribe opiates or medical marijuana for the treatment of chronic pain, or benzodiazepines for the treatment of chronic anxiety or insomnia.
- She does not take over the prescribing of these medications from another physician.
- Dr. Howell is required by law to review my prescription refill habits through the Prescription Monitoring Program, even if she is not prescribing me a controlled substance. Dr. Howell always communicates with prescribing physicians about my treatment plan if it is related, even if she is not also prescribing me controlled substances.

Attorneys :

- In the event Dr. Howell is required to work with an attorney, or is required to appear in court, the current hourly rate, billed by the quarter hour or fraction thereof, will be charged, based on the most recent Attorney Fee Schedule.

Privacy Practices :

- This clinic abides by federal privacy regulations and keeps my protected health information (PHI) confidential. We will safeguard your information and generally only share your information with your verbal or written permission.
- Exceptions to this include for the purposes of treatment, payment, or healthcare operations, as well as if you are a danger to yourself or others; and if we are obligated to comply with an investigation.

Violence and Threats :

- Any threats or aggressive or violent behavior directed toward staff, other patients, or neighboring businesses will result in dismissal from the practice.

Updates :

- We will update these policies from time to time. You may review the latest policies on request.

By voluntarily signing below, I acknowledge that I have read, or have had read to me, the above informed consent, and understand and accept these statements.

PRINTED NAME of Patient or Legally Authorized Representative

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Signature _____ Date_____