RICHARD HEIDENFELDER, M.D.
826 ORANGE AVENUE
SUITE 605
CORONADO, CALIFORNIA 92118

OFFICE AND FINANCIAL POLICIES AGREEMENT

INTRODUCTION:

Welcome to our medical office. We are committed to providing our patients with the best possible care. Your clear understanding of our office and financial policies is very important, thus, we are available to discuss our professional services with you at any time. In addition to our office and financial disclosures, we value an open forum for a long-term physician-patient relationship. This Agreement is intended to communicate our practice values, adherence to strict consumer laws and all state and federal healthcare laws.

All patients must complete our "Patient Information Form" before seeing Dr. Heidenfelder. Please take time to read carefully the following paragraphs and communicate your consent to our legal and treatment requirements, and goals by signing at the end. Thereafter, you will be given your copy. If you have any questions during this process, please, do not hesitate to ask.

With all the new changes in healthcare, reimbursement to physicians has decreased making it even more difficult to maintain a solo practice. For years, at patients' requests Dr. Heidenfelder has provided letters, disability forms, and other medically related documents and services for free. He is determined to maintain his accessibility for his patients, even if it that means he works for no compensation after hours and on weekends. In order to remain in business and provide a personal touch of a true medical doctor sharing in the healing of his patients, Dr. Heidenfelder has taken example from many other dedicated medical practices and will have to charge a yearly **Membership Fee**

Dr. Heidenfelder and our office staff take pride in going above and beyond most medical offices in order to provide our patients with the treatment and service they deserve.

AGREEMENT

This is an Agreement entered into on _____, 20 _____, by and between **Dr. RICHARD HEIDENFELDER, whose practice is located at 447 9th Ave, San Diego CA 92101, and**
_____, (**Patient**).

NOW, THEREFORE, the parties agree as follows:

BACKGROUND

In exchange for certain fees paid by Patient for **Annual Membership Fee** Dr. Richard Heidenfelder agrees to provide Patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement.

DEFINITIONS:

Applicable Law. Federal Law and Regulation: Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI. Regulation, Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).

Non-Covered Services. A non-covered service is a service, item, or supply for which insurance reimbursement is not available.

Patient. A patient is for whom the Physician shall provide Services and provide their signature to this agreement.

Services. Services includes a package of non-Medical treatments (collectively referred to as "Services), which are offered by the Practice. Services will be listed in this Agreement.

Terms. This Agreement starts on date signed by the parties below and shall continue for a period of one month, automatically renewed, unless the Patient notifies the Practice in writing **thirty (30) days** prior to the end of the term that the Patient wants to terminate the contract.

Fees. In exchange for the services in the Agreement, the Patient agrees to pay the Practice at the time this Agreement is started, the amount as set forth in this **Agreement**. The fee is in payment for the services provided to Patient during the term of this Agreement. If this Agreement is cancelled by either party before the Agreement termination date, then the Practice shall refund the Patient's prorated share of the original payment, remaining after deducting individual charges for services rendered to Patient up to cancellation.

Annual Membership Fee

Fee schedule shall be as follows:

One Year Individual: Three hundred dollars ($300.00) per year. Payment due at signing of this Agreement.

PAYMENT:

Payment for non-emergency services is required prior to your session. If you are unable to render payment, the front office will reschedule your appointment. Our office accepts cash, check, Visa, MasterCard, and Discover. If a check is returned for insufficient funds, future payments cannot be made with checks. There is a **$25 returned check fee**. For new patients, we do not accept temporary/post-dated checks.

OUTSTANDING BALANCES:

Any patients that have a balance due may be refused any non-urgent treatment until all outstanding balances are paid in full. Should you have any problems regarding your account or about the filing of claims, fees, or billing records, please do not hesitate to ask our Business Office Staff.

24 HOUR NOTICE OF CANCELLATION:

Unless notified twenty-four (24) hours in advance, there will be a fifty dollar ($50) charge for missed/canceled appointments. Please do not rely on appointment reminder calls, as this is a courtesy. Having three (3) or more "no shows" or cancellation of appointments can result in termination of treatment. Please help us serve you better by keeping scheduled appointments.

INSURANCE:

Patient understands and agrees that neither Practice nor its physicians make any representations whatsoever that any fees paid under this Agreement are covered by Patient's health insurance or other third-party payment plans applicable to the Patient. However, if the services rendered are covered by insurance, Practice will seek reimbursement from applicable insurance plan, whether private insurance and/or government sponsored insurance. In the event that the services are not covered, Practice will seek reimbursement from Patient. The patient shall retain full and complete responsibility for any such determination.

NO INSURANCE OR OTHER MEDICAL COVERAGE:

Patient acknowledges and understands that this Agreement is **not** an insurance plan, and **not** a substitute for health insurance or other health plan coverage (such as membership in an HMO). It will not cover hospital services, or any services not personally provided by Practice, or its physician.

Patient acknowledges that Practice and its physician have advised patient to keep in full force such health insurance policy(ies) or plans that will cover Patient for general healthcare costs.

Patient acknowledges that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any

existing or future health insurance or health plan coverage that Patient may carry.

TERM;TERMINATION:

This Agreement will commence on the date first written above and will extend monthly thereafter. Both Patient and the Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving **30 days prior written notice** to the other party. Unless previously terminated as set forth above, at the expiration of the initial one-month term (and each succeeding monthly term), the Agreement will **automatically renew** for successive monthly terms upon the payment of the monthly fee at the end of the contract month.

COMMUNICATIONS:

Patient acknowledge that communications with the Physician using e-mail, facsimile, video chat—telehealth, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. As such, Patient expressly waives the Physician's obligations to guarantee confidentiality with respect to correspondence using such means of communication. Patient acknowledges that all such communications may become part of Patient's medical records.

EMAIL COMMUNICATIONS:

By providing Patient's e-mail address Patient authorizes the Practice and its Physicians to communicate with Patient by e-mail regarding Patient's "protected health information" (PHI)(as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations).

By inserting Patient's e-mail address below, Patient acknowledges that:

☒ E-mail is not necessarily a secure medium for sending or receiving PHI and there is always a possibility that a third-party may gain access and confidentiality may be compromised, despite diligent and good faith measures taken by the Practice and its Physician in securing the Patient's PHI;

☒ E-mail communications are considered a part of the Patient's permanent medical record; and

☒ Patient understands and agrees that e-mail communication is not the correct

means of communication for emergency or other time-sensitive issues. Nor is e-mail communication the appropriate means for questions about sensitive information.

☒ If Patient does not receive a response to an e-mail message within 24 hours, Patient agrees to use another means of communication to contact the Physician.

☒ Neither the Practice nor the Physician will be liable to Patient for any loss, cost, injury, or expense caused by, or resulting from a delay in responding to Patient as a result of technical failures including, but, not limited to: Technical failures attributable to any internet service provider, power outages, failure of any electronic messaging software, failure to properly address e-mail messages, failure of the Practice's computers or computer network, or faulty telephone or cable data transmission, any interception of e-mail communications by a third party; or patient's failure to comply with the guidelines regarding the use of e-mail communications outlined in this Agreement.

☒ **IN THE EVENT OF AN EMERGENCY, OR A SITUATION IN WHICH THE PATIENT COULD REASONABLY EXPECT TO DEVELOP INTO AN EMERGENCY, PATIENT SHALL CALL 911 OR THE NEAREST EMERGENCY DEPARTMENT AND FOLLOW THE DIRECTIONS OF THE EMERGENCY PERSONNEL**.

CHANGE OF LAW:

Patient understands that healthcare and consumer protection laws change, and in complying with those laws the Practice wants to protect its Patients. Thus, if any change in federal, state or local law, regulation or rule affects the Practice/Physician and/or Patient's rights, obligations or operations associated with any term or condition of this Agreement, or if either party to this Agreement reasonably believes in good faith that such change will adversely affect that party's rights, obligations or operations associated with this Agreement then that party may, upon written notice, require the other party to renegotiate the terms of this Agreement. If the parties are unable to reach an agreement within forty-five (45) days after the effective date of change, then either party may immediately terminate the Agreement by written notice to the other party. We reserve the right to amend the Office Policies/Non-Covered Services Contract at any time.

SEVERABILITY:

If for any reason, any provision of this Agreement is determined by a court of competent jurisdiction to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected. The provision deemed legally invalid

shall be deemed modified to the minimum extent necessary to make that provision consistent with the applicable law. In its modified form, that provision shall then be enforceable.

REIMBURSEMENT FOR SERVICES RENDERED:

If this Agreement is held to be invalid for any reason, and, therefore, if the Practice needs to refund all or any portion of the monthly fees paid by Patient, then Patient agrees to pay the Practice the reasonable value of the Services actually rendered to Patient.

AMENDMENT:

If applicable law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference and deemed part of this Agreement as though they had been expressly set forth into this Agreement and shall be deemed a part of this Agreement as thought they had been expressly set forth in this Agreement. Otherwise, no amendment to this Agreement shall be binding on a party unless it is made in writing and signed by all the parties.

ASSIGNMENT:

This Agreement is personal to the Patient, thus, this Agreement may not be assigned or transferred by Patient.

LEGAL SIGNIFICANCE:

Patient acknowledges that this Agreement is a legal document and creates certain rights and responsibilities. Patient also acknowledges having had a reasonable time to read and ask questions regarding this Agreement and to consider all alternatives and implications to signing this Agreement and does so without general or medical duress, and/or incapacitation. Thus, Patient is satisfied with the terms and conditions of the Agreement.

ENTIRE AGREEMENT:

This Agreement contains the entire agreement between the parties and supersedes any oral or written understandings and agreements regarding the subject matter of this Agreement.

JURISDICTION/GOVERNING LAW:

This Agreement shall be governed and construed under the laws of the

State of California and all disputes arising out of this Agreement shall be settled in a court of proper venue and jurisdiction in the County of San Diego, without giving effect to conflict of laws.

SERVICE:

All written notices are deemed served if sent to the address of the party written above, by first class U.S. mail, certified with return receipt or by personal service with signed affidavit.

MISCELLANEOUS:

This Agreement shall be construed without regard to any presumptions or rules of construction against the drafting party. Captions in this Agreement are used for convenience only and shall not limit, broaden or quality the text.

_____

Dr. Richard Heidenfelder
619-435-4088 (office)
619-435-4088 (fax) Email:

_____

Patient (printed)

_____

Patient Signature

_____

Patient E-mail Address
Pages to follow:

PLEASE REVIEW AND INITIAL THE FOLLOWING POLICIES FOR TREATMENT:

___ ITEM 1 – CONSENT FOR TREATMENT – CONSENT MUST BE SIGNED PRIOR TO THE START OF YOUR INITIAL APPOINTMENT

I hereby give consent, for myself, or the above named patient to be treated/tested by RICHARD HEIDENFELDER M.D. If the above named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court documents that I have the legal right to request treatment for the above named minor.

If you are fifteen to seventeen (15-17) years of age, you must co-sign.

If you are eighteen (18) years of age, you must sign yourself and are allowed the right to choose whether you wish anyone/parents to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co-joint therapy. Patients under eighteen (18) years of age will only be seen with a parent or guardian present.

___ ITEM 2 – THERAPY SESSIONS

Initial/ Therapy sessions are scheduled for thirty or forty-five (30 or 45) minutes. So that you receive your entire session, please be prompt for your appointment.

___ ITEM 3 – CONFIDENTIALITY

Initial/ All information is guarded by strict confidentiality. We require your written consent in order to release/obtain information. Any additional person that is willfully allowed to be present during an appointment implies consent to the release of information.

___ ITEM 4 – LETTERS AND/OR FORMS

Initial/ The *Practice Administration Fee* covers the expense for any forms and/or letters that must be completed in this office by any practitioner or office staff.

___ ITEM 5 – TERMINATION OF TREATMENT

Initial/ Physical Assault, verbally threatening behavior towards staff, other patients, or physical property, and/or significant disruption of the office environment will be cause for immediate termination of treatment and you will be held responsible for damages.

Firearms and other weapons are prohibited, with exception for an officer of the law. Non-compliance with treatment (missed appointments, failure to follow treatment plans, misuse of medications, and violation of any office policies) is grounds for termination of treatment.

___ITEM 6- OFFICE BEHAVIOR

Initial/ All patients are expected to act professionally and appropriately at the office.

No eating or drinking in the office. Food and beverages may be consumed outside on the front porch.

No cursing, inappropriate language, or inappropriate discussions are allowed. Any patient(s) who are deemed to be behaving inappropriately will be asked by the office staff to reschedule their appointment.

Childcare is not provided for children. Please do not leave children unattended in the reception area.

We ask that ONLY essential family members or mental health providers attend scheduled appointments. Our office is small and seating is limited and is provided for patients and essential family members only. Any additional visitors may be asked to leave the office property, (including the front porch area), and wait off premises.

Please do not disrupt office staff. Any questions/comments/requests beyond the required information needed at your appointment will need to be submitted to the office via email.

Please do not use your cell phone in the office/waiting area.

Do not discuss confidential patient information, appointment time, etc., with other patients who are waiting.

Patients violating any of the above rules may be asked to reschedule their appointment.

Any patients who repeatedly violate these rules will be terminated from the practice.

___ ITEM 7 – CANCELLATIONS

Initial/ New Patient Evaluation Cancellations must be made 5 days before your session. Your session time is reserved for you and you will be charged the full $100 deposit required to hold the Initial Evaluation appointment time. There is a $50.00 no-show fee for late cancellations or

missed appointments. Our office policy allows three no-show fees before terminating services.

You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you are late for your appointment and are asked to reschedule you will charged a $50 no-show fee. If you feel you were charged in error, please discuss this matter with our office manager.

___ ITEM 8 – EMERGENCY SERVICES

Initial/ I agree to contact the office at 619-435-4088 and call 911 in the event that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

___ ITEM 9 – FINANCIAL POLICY

Initial/ I acknowledge that I have read and understand the financial policies of this office.

___ ITEM 10 – NOTICE OF PRIVACY PRACTICES

Initial/ I acknowledge that I have received a copy of the Notice of Privacy Practices of this office effective April 21, 2013.

___ ITEM 11– BILLING INQUIRIES

Initial/ If you have billing questions, we will be pleased to help you. Contact our billing office at 619-435-4088.

___ITEM 12 – REFILLS

Initial-Refills will not be given in cases of pharmacy errors. Patients will need to speak to their pharmacy directly in those cases.

By initializing Items 1 – 12, I indicate my agreement and understanding of my responsibility and expectations in receiving proper treatment in a timely manner by Richard Heidenfelder, M.D.

_____

Dr. Richard Heidenfelder
619-435-4088 (office)
619-435-4088 (fax) Email:

_____

Patient (printed)

_____

Patient Signature

_____

Patient E-mail Address