Stephen M. Swetech, DO Medical Center, PC
Financial Responsibility, Consent to Treat, HIPAA Consent, and Policies (1 of 3)

By signing below, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that Stephen M. Swetech, DO Medical Center, PC may use my health information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services rendered and for determining insurance benefits or the benefits payable for related services. I understand that collection fees may apply if services are not paid for in a timely fashion. I understand that co-pays, prior balances, and deductibles are collected up front by the intake staff, prior to services rendered.

I understand that I need to take an active role in my own health. I understand that the practice of medicine is not an exact science. I understand that all medical treatments, medications, procedures, and osteopathic manipulations carry risks that can include anything from allergic reaction, infections, damage to tissue and organs, stroke, heart attack, all the way up to death. Refusing or being non-compliant with medical advice/testing/treatment can also have the same risks. Some medications can also cause suicidal or homicidal ideation. I will not drive or operate heavy machinery while using mind altering substances. I give my consent to treatment knowing this reality and take all liability for my own care. I understand that my physician is weighing risks vs benefits and trying to make the best recommendations given all the variables of my case. I am responsible for providing a accurate updated medication and allergy list and each visit. I should familiarize myself with each medication I am taking, why I am taking it, and the relevant side effects. I will not bring legal action against the office, staff, providers,students, building owners, associates, etc. I will make sure to ask any questions I may have and will voice my concerns if I am uncomfortable with the risks and benefits or I don't fully understand my condition and/or treatments. I consent to tissue examination by a pathologist if deemed necessary. I consent to drug screening randomly or if deemed necessary. I understand that the prescribing of controlled substances can be stopped for any reason, if any withdrawal symptoms I will go to the emergency room. I understand that follow-up and monitoring is important on all medical conditions and concerns. I understand that many refills will not be given without this monitoring and follow-up. This includes all medications and if I do not follow recommended follow up I may need to go to urgent care or an ER for refills. If not instructed otherwise, I will follow-up at 3 month intervals. I will make and attend preventative visit annually where preventative services will be addressed. I am responsible for making my own appointments for testing and with specialists that I am referred to. I will call the office to follow up on test results if I do not hear anything in a reasonable time frame.

If I have new, continued, or worsening symptoms I will notify the staff of Stephen M. Swetech, DO Medical Center, PC and/or go to the nearest emergency room preferably by calling 911. I will call 911 if I have any suicidal or homicidal thoughts. I will call 911 if I use an epinephrine pen for follow-up. In the event of a needle stick or exposure to body fluids by staff, I consent to testing of communicable diseases, including HIV. I understand that I may be discharged from the practice for non-compliance or any breakdown of doctor-patient relationship. I will value the offices time and will come to my appointments as scheduled. I understand that I may be charged a $35 fee if I am 15 minutes late for an appointment or fail to show and may be required to reschedule my appointment.

I understand that prior authorizations for medications are very time consuming to obtain and are often denied, delaying treatment. I understand that appropriate medications will be substituted from my insurance's formulary unless there are no other options. I understand that purchasing these medications from a pharmacy is an option as well. I understand that pharmacies routinely fax refill requests that aren't requested or needed, therefore I will contact Stephen M. Swetech, DO Medical Center, PC instead of my pharmacy if I need a refill. I understand that it can take up to three business days for refills left on the refill line and will plan accordingly. I understand that if I am not following up as instructed, my refills may be declined. I will not call the refill line for refills on controlled substances. I understand that mixing medications with any other mind-altering, controlled, or even over the counter substances can be dangerous. I will not sell or share my medications with others. I will dispose of medications at a designated medication disposal sites or a pharmacy. I will be honest with the staff.

I understand that referrals and pre-authorizations for testing take time to arrange, often up to a week, and will plan accordingly. I will submit all necessary information to the referral coordinator with plenty of time to allow for processing. I understand that any appropriate forms that may be completed other than insurance health-risk assessments are not included and may carry a fee for completion. These forms must be provided to front desk prior to the visit. I understand that my physician is interested in maximizing function and forms for disability are not routinely done except in appropriate circumstances. I will stay aware of office hours and understand that calls to the answering service deemed non-urgent are subject to a fee for the physician's time.

Patient's name printed: _____

Patient or Representative Guardian Signature:_____Date:_____

Stephen M. Swetech, DO Medical Center, PC
Financial Responsibility, Consent to Treat, HIPAA Consent, and Policies (2 of 3)

By signing below, I will be polite to staff. I understand I am free to go anywhere for my testing, prescriptions, specialists and the suggestions provided are merely out of convenience and/or based off of a record of good experiences. I understand that the staff will try to address as many of my concerns as possible at each visit however I will keep each visit to a few main issues. I understand that trying to address too many problems at once can affect the thoroughness which in turn can be problematic. I am aware that I am welcome to make additional appointments to make sure all my issues are thoroughly addressed. I understand this is a teaching facility and consent to the involvement of students in my care with the understanding that I can request they not be involved. I consent to the treatment by mid-level providers if applicable to my care. I will not publicly defame or negatively mark the office, staff, facilities, etc. I won't leave negative reviews online and will remove reviews if asked. I will not misrepresent my insurance coverage or try to seek care for auto/work related injuries under my medical insurance coverage.

I understand that the credit card machine is provided as a convenience and agree to a potential 2$ transaction fee for processing should I use it. I understand that the required documentation for any durable medical equipment (DME) or medical supplies is quite specific/extensive and almost always requires a specific office visit. I understand that filling out paper work takes quite a bit of time and review and outside of simple work notes there will be fees assessed for the initial and follow up forms. In the event that paperwork is needed in relation to work restrictions, FMLA, disability, other insurance forms or legal paperwork, determinations for benefits and time off are made by their respective third party and thus not guaranteed. I consent to the release of my health information to any involved parties. I understand that cosmetic and regenerative therapies are not covered by insurances. There will be a $35 fee for returned checks.

In regards to health screenings, I am aware that screening guidelines are updated frequently and sometimes are conflicting, I will investigate screening guidelines on my own and if I am interested in any specific screenings not already offered, I am responsible for bringing them up on my own. I understand that treatment guidelines are also updated frequently and sometimes conflicting or incomplete as well, I will investigate treatment guidelines on my own and if I am interested in any changes to the plan I will bring these changes up. I will make sure to follow up on abnormal test results and bring them up to the providers at follow up visits for continued surveillance and management over time. I understand that no medical test or exam is 100% accurate. I consent to HIV screening if the ordered by the physician, along with other tests deemed necessary. I understand that certain communicable diseases and medical conditions must be reported to appropriate authorities. If there is any chance that I am pregnant, I will make the staff aware. I understand that some medical issues have a latency period and they can take some time to show up in testing. If I have concerns related to this type of issue, I will make a follow up appointment for retesting. I will not fake or make up fraudulent symptoms, exaggerate symptom severity, or act in a way to influence or skew physical exam findings. I will follow-up appropriately after urgent care, ER, or hospital visits or any operations to discuss treatment course, testing, etc. I understand that I will be evaluated for my conditions at each visit and certain medications are not guaranteed fills/refills if deemed inappropriate by my provider. I understand it is difficult to accurately treat medical issues over the phone and will strive to be evaluated in office for all issues, especially new ones. Anytime I have a test performed, I will review the results in person with a provider at a formal office visit. I will monitor my bp and contact the office if my blood pressure readings are above 140/90.

In response to new laws, this takes the place of a “Start Talking form”. I am aware a controlled substances, while rarely prescribed at this office, are drugs or other substances that the US Drug Enforcement Administration has identified as having a potential for abuse. Controlled substances, including benzodiazepines, opiates, and stimulants, have a risk of causing a substance use disorder or overdose causing any effect up to and including death. Mixing opioids with benzodiazepines, alcohol, muscle relaxers, or any other drug that may depress the central nervous system can cause serious health risks, including death or disability. For a female who is pregnant or is of reproductive age, the heightened risk of short and long-term effects of opioids,including but not limited to neonatal abstinence syndrome. Any other information necessary for patients to use the drug safely and effectively is found in the patient counseling information section of the labeling for the controlled substance. Safe disposal of opioids has been shown to reduce injury and death in family members. Proper disposal of expired, unused or unwanted controlled substances may be done through community take-back programs, local pharmacies, or local law enforcement agencies. Information on where to return your prescription drugs can be found online governmental websites. It is a felony to illegally deliver, distribute or share a controlled substance without a prescription properly issued by a licensed health care prescriber. I acknowledge the potential risks involved with the use of controlled substances.

Patient's name printed: _____

Patient or Representative Guardian Signature:_____Date:_____

Stephen M. Swetech, DO Medical Center, PC
Financial Responsibility, Consent to Treat, HIPAA Consent, and Policies (3 of 3)

In April of 2003, new federal requirements regarding privacy of information for patients took effect. HIPAA, the Health Information Portability and Accountability Act requires that all providers, insurance companies, and others put in place controls to ensure that your personal medical information is safe. The Stephen M. Swetech, DO Medical Center, PC requests that each patient sign this consent form which allows us to share protected health information with other physician's offices, hospitals, insurance company(ies), and authorized individuals.

Our Notice of Privacy Practices provides information on how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I understand that e-mail is not secure and is generally not used by the office. However in the event that e-mail is deemed appropriate out of convenience I allow the transmission of my personal health information via email. I understand that the office does not regularly check e-mail and any communication via this medium will usually not be read or responded to. I will not try to reach the office or staff for medical advice via social media as this communication medium will usually not be read or responded to either. I understand the office does not routinely publish patient information but allow the release of my information/picture/video if specifically taken for a certain media purpose. In respect of the privacy of other patients, I will not make any recordings at the office. If a recording is required, I will ask and obtain written permission first.

By signing below, I acknowledge that it is my responsibility to make sure the Stephen M. Swetech, DO Medical Center, PC has up to date contact information. I authorize the Stephen M. Swetech, DO Medical Center, PC staff to leave messages about concerns or results on my voicemail or with household members as deemed reasonable by the staff. The Stephen M. Swetech, DO Medical Center, PC staff may discuss these concerns or results to anyone answering provided phone numbers within reason, unless I specifically instruct them otherwise in writing. I give my consent for the Stephen M. Swetech, DO Medical Center, PC to request and obtain medical records from other providers/hospitals as necessary. The Stephen M. Swetech, DO Medical Center, PC may release medical information to emergency contacts, and other medical providers involved in my care. Many of our patients allow family members, friends, or significant others to call and request the results of tests and procedures. Under the requirements of HIPAA we are not allowed to give this information to these individuals without the patient's consent. In addition to the individuals and entities authorized above, I authorize the Stephen M. Swetech, DO Medical Center, PC to release my protected health information to the following individuals:

1.) _____ Relation to Patient:_____
2.) _____ Relation to Patient:_____

Patient's name printed: _____
Patient or Representative Guardian Signature:_____Date:_____

Patient Information:

Full name: _____
DOB: _____

Address: _____
_____

****Current Phone****: _____
Secondary Phone: _____

Marital status: _____
Social Security #: _____
How did you hear about us? _____
Religious Preference: _____
Race/Ethnicity: _____

Emergency Contact: _____
Phone number: _____
Relationship: _____

Employer: _____
Address: _____
_____
Employer phone: _____

Do you have an advanced directive? _____(please provide a copy for your medical record)

Update to medical history:

Past medical problems: _____
_____

Past surgeries: _____
_____

Medical problems in family: _____
_____

Tobacco use?: _____
Alcohol use?: _____
Illicit drug use?: _____

Last dental visit (you need to see dentist at least twice annually)?: _____
When was your last colonoscopy (if done)?: _____

Patient or Representative Guardian Signature: _____Date:_____

Reviewing Physician Signature: _____Date:_____