Consent to Treat and Consent to Financial Responsibility

Frontier Health and Wellness (on behalf of its contracted providers)

_____ (Initial)***Guarantee of Outcomes:*** I recognize that no guarantee of a specific outcome has been provided. Payment of a service fee does not guarantee or imply specific results from any services provided to the patient. This includes but is not limited to therapy, medication treatments, exams or procedures for a patient of a Frontier Health and Wellness contracted provider.

_____(Initial)***Divorce/Custody:*** In the event of a divorce/multi-home families, Frontier Health and Wellness will need a copy of the custody documentations from court. Frontier Health and Wellness providers provide services and seek involvement of both parents/interested parties within reason of a custody plan. Pleasenote that thedefaultposition of any provider without a signed parenting plan is to assume 50/50 legal andphysical custody of eachparent. If legal custody is 50/50 shared then Frontier Health and Wellness providers will require one parent to be the primary contact/sponsor for any employee contacts and billing purposes. This will notprevent the other parent from participation in patient care and accessing treatment recommendations or documentation. In the absence of custody paperwork, the default position is to assume that both parents maintain 50/50 custody.
Primary Parental Contact: _____.

_____(Initial)***Assignment of authorization to negotiate on your behalf regarding insurance benefits and payment:*** In consideration of any and all treatment services rendered or to be rendered by Frontier Health and Wellness and its contracted providers, to the extent permitted by law, I hereby permanently assign, handover and set over to Frontier Health and Wellness and its providers providers all my rights, title and interest to medical reimbursement, containing, but not restricted to, the right to name a beneficiary, add dependent eligibility and to have an individual policy sustained or allotted in agreement with the terms and reimbursements under any insurance policy, compensation certificate or other health benefit indemnification reimbursement otherwise payable to me for those services rendered by Frontier Health and Wellness providers in the interim of the claim for care provided by Frontier Health and Wellness contracted providers.
Such irrevocable allocation and assignment shall be for the recovery on said policy or insurance, but shall not be construed to be an obligation of Frontier Health and Wellness or its providers to pursue any such right of reclamation. I authorize the insurance company or tertiary client to pay directly Frontier Health and Wellness contracted providers all reimbursements due for services received.

_____ (Initial)***Assurance of Compensation:*** I understand and agree that the payment of the financial obligation for services rendered by Frontier Health and Wellness contracted providers will paid. I agree whether signing as a guarantor or as a patient, that in consideration of the services to be provided to the patient, to be hereby jointly and individually obligated to pay the account of Frontier Health and Wellness' contracted providers in accordance with the regular rate and terms of each of Frontier Health and Wellness' contracted providers. Should the account be referred for collection by an attorney or collection agency, I agree to pay all of the amount not referred for collection by an attorney or collection agency, I agree to pay all of the amount not paid when owed. If legal custody is shared contact/guarantor for any staff contacts and billing purposes. 50/50 by both parents, then Frontier Health and Wellness and its contracted providers will require one parent to be the main contact/guarantor for any staff contacts and billing purposes.

_____**(Initial) Court Proceedings:**Frontier Health and Wellness contracted providers provide clinical services and do not conduct Forensic or Custody evaluations. FHW contracted providers will independently decide, on a case by case basis, to take part in court actions or provide opinions on court issues. Initialing this line indicates my agreement that neither I, nor my representative will subpoena Frontier Health and Wellness or its contracted providers for matters related to this case.

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_____(Initial)***Cancellation Policy and Agreement:*** Appointments should be canceled within 48 hours or more to avoid a 50% missed appointment fee; an email, or a message for cancellation that is left on the Frontier Health and Wellness voicemail or your providers voicemail 48 hours or more before the appointment will qualify as appropriate notification. The 50% fee will need to be paid at or prior to the next scheduled appointment. Insurance companies DO NOT cover missed appointment or late cancellation fees. The client/family will be solely responsible for all missed appointment or late cancellation fees and will need to provide payment by cash, check or credit card to their provider or their providers contracted billing company. Frontier Health and Wellness contracted providers reserve the right to extend the fee to 100% of the appointment fee when a pattern of missed appointments occurs involving two or more missed appointments.

_____(Initial)***Confirmation Calls:*** I understand that all confirmation calls, emails or texts are a courtesy that Frontier Health and Wellness may provide on behalf of my provider(s), but the absence of a confirmation call does not negate the cancellation policy agreement.

_____(Initial) ***Medical Record Requests:*** Frontier Health and Wellness staff will work to manage these requests on behalf of each provider. These requests will be handled in a reasonably expeditious fashion and in accordance with Alaska statues. *Please note that court orders do not require a release of information from the patient or guardian.*

Record requests from health care facilities, mental health clinics, hospitals, academic centers and other related institutions will require a fully completed and signed Frontier Health and Wellness contracted provider Release of Information (ROI) to be on file. These releases can be found on the FHW website or one can be provided to you during your office visit. If you have any questions on how to fill the document out please contact the FHW front desk.

There are very few instances that a refusal of release medical records may occur. Although we reference three such instances here, others may occur as well.

1. Records that contain information subject to substance abuse or health issues without appropriate ROI on file will not be sent.
2. The release of the records breaches patient confidentiality or HIPAA regulations.
3. The release of records has the potential to endanger the health or safety of a patient or member of the community.

Once the records request has been reviewed and approved, the staff at Frontier Health and Wellness has 3-5 business days to complete the request on behalf of your provider. If for any reason this request is denied the patient and requester will be notified of the denial within 3-5 business days.

_____ **(Initial) Emergencies:** In the case of a psychiatric/psychological emergency (e.g. harm to self or others), patients are instructed to call 911 or, if able, go to The Providence Psychiatric Emergency Room in Anchorage; 3200 Providence Drive Anchorage, AK 99508. I understand that Frontier Health and Wellness or its contracted providers do not provide emergency or after hours call services or medical care and will use the above listed resources in the event of any psychiatric/psychological emergency.

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_____ **(Initial) Electronic Communication and Phone Contact:** I understand that electronic communication; whether through email or the client portal; phone calls, refill requests and other associated correspondence with an FHW contracted provider are all tasks that require time and resources. Due to this, the above mentioned correspondence is often a billable service.

Note: Insurance coverage of these types of services is inconsistent and varies by coverage plan. Please check with your insurance company to determine what level of coverage you have regarding these types of electronic, telephonic, remote and non-face-to-face services.

_____ **(Initial) Frontier Health and Wellness; Contracted Providers:** I understand that Frontier Health and Wellness is a medical management company that contracts with clinical care providers. Each physician/ clinician that provides treatment at FHW is an independent contractor. Each provider is responsible for their treatment, clinical management and billing submissions. Since our providers submit their own billings under their own entities, all insurance submissions, Explanation of Benefits and bills will be under those individual entities. Please consult the Frontier Health and Wellness provider information page or the FHW website for information on each providers individual entity.

I have read the above Consent to Treatment and Consent to Financial Responsibility document from Frontier Health and Wellness on behalf of its contracted providers. I understand and accept all the terms set forth above. All of my questions and concerns have been answered and addressed by Frontier Health and Wellness staff or my provider prior to signing and submitting this document.

Printed Name of Patient or of Legal Guardian	Relationship to Patient
Signature Patient or of Legal Guardian	Date