ELITE SPORTS PERFORMANCE MEDICINE
RESTORE THE ATHLETE WITHIN

Adam M. Pourcho, DO, ATC, ARDMSK

Elite Sport Performance Medicine

FINANCIAL POLICY

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. Elite Sports Performance Medicine (ESPM)expects payment for clinic visits ***at the time of service*** and does not directly bill your insurance company. This includes motor vehicle collision (MVC) cases with open personal injury protection (PIP) insurance coverage. ESPM will provide you with a superbill with the necessary codes to submit to your insurance company, HSA, FSA or other entity for reimbursement for services obtained from our out-of-network specialist provider. The amount of the coverage varies by insurance plan and we cannot guarantee payment from your insurer. We recommend you call the phone number of the back of your insurance card to find out your out-of-network specialist benefit in advance. Medicare and Medicaid do not cover our services. Our view is that insurance companies are first and foremost businesses whose primary objective is to profit, sometimes by controlling costs. We believe that goal does not always translate into doing what is best for your health. We are committed to doing what is best for our patients.
2. **Every patient should register for our secure invoicing/payment system at the first visit** (even if paying via cash or check).
3. **ESPM prefers payment by cash or check**. This avoids a 3-4.5% credit card processing fee. There will be a $50 fee for any not sufficient funds (NSF) checks. **Past due balances will incur interest charges of 2.5% per month, due to be paid at the end of each month**. The patient is responsible for all fees accumulated if the account is sent to collections, small claims court or other means of collection.
4. ESPM also accepts credit/debit cards, direct bank transfer, health savings account (HSA) and flexible spending account (FSA) accounts via our secure electronic payment system. Please inquire prior to first appointment
5. Every patient is required to keep an active, valid payment source on file (credit/debit card, HSA, FSA, bank account or a $1000 deposit) to cover invoices that cannot be billed directly at the time of service such as visits completed via telephone/ telemedicine/ email/ text, late-cancel/ no-show fees, or unpaid balances. Typically, you may receive 10 days' notice as a courtesy prior to a charge. **However, the payment source on file may be billed at any time with no advance warning for any outstanding balance. Your signature below constitutes authorization for ESPM to bill the credit/debit card, bank account, HSA, FSA, deposit or other payment method on file.** We do not bill third parties (i.e. the liable party), accept liens, letters of guarantee or other alternative forms of payment. Any deposit will be reimbursed to you upon completion of care and payment for all medical services.
6. We order the majority of our imaging through Center for Diagnostic Imaging (CDI), and lab work through LabCorp, which are contracted with most insurance companies. Your imaging will typically be billed directly to your insurance company. Your labs can be billed directly to your insurance or through ESPM if you choose.
7. **If you have a past due balance on your account you will not be permitted to schedule further appointments.**
8. Some, and perhaps all, services provided may be considered as not being reasonable and necessary under your medical insurance plan benefits. **You are responsible for payment regardless of any insurance company's determination. This pertains to all insurances (including motor vehicle).**
9. If you need to cancel an appointment we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care. **There will be a $200.00 no-show fee for any new patient and $100.00 no-show fee for any follow-up patient appointments not cancelled at least 24 hours prior to the scheduled appointment time.** Arrival 15 minutes or more after the scheduled appointment time is considered a no-show and may need to be rescheduled. This fee will typically not be paid by private insurance or PIP coverage. All no-show/late-cancelation fees must be paid in full before the next appointment is scheduled. We offer confirmation reminders as a courtesy but these are not guaranteed. Please keep track of your scheduled appointment times. We reserve the right to discharge any patient that misses 3 or more scheduled appointments without giving 24 hours' notice.
10. **The fee schedule is available for your review by contacting ESPM directly, is subject to change at any time with no warning and may not be updated on the website or other places. There may be charges for telephone calls, emails, text messaging, video conferencing, coordination of care with other providers or attorneys, extended time with the doctor, record review or other services provided by ESPM that may or may not be reimbursed by your insurance company.**

Adam M. Pourcho, DO, ATC, ARDMSK

FINANCIAL POLICY

I authorize Elite Sports Performance Medicine to electronically debit my financial account and, if necessary, electronically credit my account to correct erroneous debits. This authorization may be revoked by notifying ESPM at ESPM@ESPMedicine.com
My signature below signifies I have read and understood my responsibility about charges incurred in this office.

_____	_____	_____	
Signature	*Relationship (self/parent/guardian, etc.)*	*Printed Name*	*Date*

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MEDICATION POLICY

1. Refill requests must be made at least 72 hours in advance for all medication.
Pain medications can not be refilled on weekends: Friday afternoon, Saturday or Sunday.

2. Medication prescriptions are typically provided to last until your next appointment.

3. Patients must be seen at least every three months if prescriptions are going to be written. However, many patients will require sooner follow-up.

4. Urgent medication or medical issues can be discussed by calling the on-call number and non-pain medication refills may be prescribed as needed. Requests for new medications or changes in dosage must be discussed while seeing physician. The office staff can not discuss new medications or change requests after your appointment is complete.

5. Patients receiving pain medication and who need to be seen in the Emergency Room or by another provider on an urgent basis must notify the other provider of their relationship with ESPM.

6. Physicians cannot write prescriptions out of state.

7. Lost or stolen prescriptions will not be replaced.

8. Medications will only be refilled early for special circumstances and only at a patient visit.

9. All prescriptions must be filled at the same pharmacy.

10. All prescriptions must be taken as prescribed.

11. Routine urine drug tests will be performed on patients being prescribed controlled substances (narcotics, benzodiazepines, etc.). This may include a urine drugs screen prior to receiving an initial prescription.

Please let us know your preferred pharmacy:

_____ _____
Pharmacy Name Pharmacy Address/Location

_____ _____
Pharmacy Phone Number Pharmacy Fax Number

Primary Care Provider Name

_____
Address

_____
Phone _____ Fax _____

_____ _____ _____
Signature *Relationship (self (self/ parent/guardian, etc.)* *Printed Name* *Date*

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient name (and any previous name): _____ Date of Birth: _____

I. My Authorization

Elite Sports Performance Medicine (ESPM) may use or disclose the following health care information (check all that apply):

- ☐ **All health care information in my medical record (Preferred)**
- ☐ Only health care information in my medical record relating to the following treatment or condition: _____
- ☐ Only health care information in my medical record for the date(s): _____
- ☐ Only other (e.g., X-rays, bills) - specify date(s): _____

Email, Short Message Service (SMS) text messaging, Phone. Telehealth and Communication Authorization

☐ **ESPM may use email, SMS text messaging and similar means to communicate my private, protected health information. I understand that email, SMS and similar means may not be HIPAA secure, encrypted or private, and that anything transmitted over the internet or these means may be potentially viewed by others. (Preferred)**

☐ **I understand that any communication including but not limited to email, SMS, secure messaging, voicemails, voicemail transcripts, verbal or other communication with ESPM may be recorded and documented in my medical record. (Preferred)**

☐ **I choose to receive care through the use of telehealth, enabling health care providers at different locations to provide safe, effective and convenient care through the use of audio-video conferencing technology including but not limited to the internet, wireless, satellite and telephone. As with any health care service, there are risks associated with the use of telehealth, including equipment failure, poor image resolution and information security issues. I understand the risks and benefits of telehealth as explained to me, have no additional questions regarding telehealth and consent to the use of telehealth in my medical care. Dr. Pourcho, DO has reviewed and discussed the information above with me. (Preferred)**

Uses and Disclosures Requiring Specific Authorization

ESPM may NOT use or disclose health care information regarding testing, diagnosis, and treatment for (check any limitations):

- ☐ HIV/AIDS
- ☐ Mental Health or Illness
- ☐ Reproductive Care
- ☐ Sexually Transmitted Diseases
- ☐ Drug and/or Alcohol Abuse

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

In addition to other healthcare professionals, you may disclose this protected health care information to:

Name: _____

Phone: _____ Fax: _____

Address: _____ City: _____ State: ____ Zip: _____

Reason(s) for this authorization to use or disclose my health care information: _____

This authorization will remain active indefinitely unless otherwise specified below:

☐ End on (date): _____ ☐ When the following event occurs: _____

Adam M. Pourcho, DO, ATC, ARDMSK

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by ESPM in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form—a form is available from ESPM or write a letter to ESPM

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Signature | *Relationship (self/parent/ guardian)* | *Printed Name* | *Date*

Adam M. Pourcho, DO, ATC, ARDMSK

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

YOUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

You can find the Summary of Privacy Practices on the next page (pg.7). If you would like to view/have a copy of our full Privacy Practices, please let the front desk know.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____	_____	_____	
Signature	*Relationship (self/parent/ guardian)*	*Printed Name*	*Date*

Adam M. Pourcho, DO, ATC, ARDMSK

To Parents and Guardians of Minor Children:

The providers and staff of Elite Sports Performance Medicine place great emphasis on the health and well-being of each and every patient in our clinic and we appreciate that you have entrusted us to provide healthcare services to your minor child. We look forward to working with you to ensure that your child receives the best health care possible.

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). If your minor child presents to the clinic unaccompanied, ***we will not be able to see the unaccompanied minor***. If the minor presents in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If they do not have consent for treatment the appointment will be rescheduled.

In an effort to provide the care needed and avoid having to reschedule your child's appointment, we have developed a *Consent to Treat Minors* form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and emergency medical treatment for your minor child when deemed necessary by qualified medical personnel. This consent form will remain in effect until revoked in writing. You may request this form from any member of our clinic staff.
Under Washington State law, minors have the right to consent to certain health care without a parent or guardian's consent.
A minor may consent to medical:

- ☐ If the minor is emancipated (legally independent) or married to someone at or above age 18
- ☐ In the event that emergency care is necessary
- ☐ For birth control and pregnancy-related care at any age
- ☐ For outpatient drug and alcohol abuse related treatment beginning at age 13
- ☐ For outpatient mental health treatment beginning at age 13
- ☐ For sexually transmitted diseases, including HIV, beginning at age 14

If a minor consents to care as allowed by law, he or she can request confidentiality for that aspect of care which would prohibit us from releasing this information to anyone, including a parent or guardian, without the minor's express written permission.

It is the philosophy of this clinic to encourage minor patients to include a parent, guardian or other trusted adult in all aspects of their healthcare including those areas noted above. For legal and other reasons, parent or guardian involvement may not always be possible. Rest assured that we would continue to provide health care services that are in the best interests of your minor child.

If you have questions regarding any of this information, please contact your child's primary care provider.

Sincerely,

ESPM, PLLC

Adam M. Pourcho, DO, ATC, ARDMSK

CONSENT FOR TREATMENT OF MINOR CHILDREN

Accompanied by an adult other than parent or legal guardian

I, _____, authorize, Elite Sports Performance
(Parent or legal guardian)

Medicine to treat _____for routine and emergency medical treatment when
(Patient name)

deemed necessary by qualified medical personnel when accompanied by:

_____,

_____,

_____.

This authorization is valid for (choose one):

☐ **Indefinitely/until further notice in writing (Preferred)**

☐ From_____ (date) to_____(date)

☐ Today's visit only

_____ _____

Signature *Relationship (self/ parent/guardian,etc.)* *Printed Name* *Date*

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AUTOMOBILE - MOTOR VEHICLE COLLISION QUESTIONNAIRE

Date of Motor Vehicle Collision: Personal Injury Protection (PIP) Claim #: _____

Place of the Collision: _____ City: _____ State: _____ Zip: _____

Injured Body Part(s): _____

Details of the crash:

- You were:
  ☐ Driver ☐ Passenger ☐ Pedestrian
  ☐ Other _____
- Were you seat-belted with lap and shoulder straps?
  ☐ Yes ☐ No
- What type of vehicle were you in at the moment of the collision?
  ☐ 4-door sedan ☐ other *(specify)*
  _____
- Who owned the vehicle you were in?
  _____
- At what speed were you traveling?
  _____ mph.
- Were other individuals in the vehicle?
  ☐ Yes ☐ No *(If yes, how many? _____)*
- Were you rear-ended?
  ☐ Yes ☐ No *(If no, describe what happened: _____)*
- How many vehicles total were involved in the collision?
  ☐ 1 ☐ 2 ☐ 3 ☐ other _____
- What type of other vehicle(s)?
  ☐ 4-door sedan ☐ other *(specify)*
  _____
- At what speed was other vehicle traveling? _____ mph.
- Did air bags deploy?
  ☐ Yes ☐ No
- There was $_____ of damage to your vehicle and $_____ of damage to the other vehicle.
- Did your head hit the windshield or anything else?
  ☐ Yes ☐ No
- Did your chest hit the steering wheel or anything else?
  ☐ Yes ☐ No
- Did your knees hit the dashboard or anything else?
  ☐ Yes ☐ No
- Did you experience loss of consciousness, memory change, nausea, vomiting, change in smell, hearing or vision?
  ☐ Yes ☐ No (*If yes, please circle*)
- Did you have immediate onset of pain.
  ☐ Yes ☐ No
  (If yes, where? _____)
- Have you had prior injury to this area?
  ☐ Yes ☐ No
- There were _____ ambulances, _____ police cars, and _____ fire trucks at the scene.
- Were you taken by the ambulance to the nearest medical facility?
  ☐ Yes ☐ No
- Was there imaging obtained?
  ☐ Yes ☐ No

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AUTOMOBILE - MOTOR VEHICLE COLLISION QUESTIONNAIRE

Your Auto Ins. Co. Name: _____ Ins. Co. Phone: _____ Ext: _____
Ins. Co. Address: _____ City: _____ State: _____ Zip: _____
Policy#: _____ Name of Your Insurance Adjustor: _____

Your Attorney's Name (If applicable): _____Attorney's Phone: _____

Do you give Elite Sports Performance Medicine permission to contact and share records with your attorney? *Yes/No*

Driver of Other Vehicle Information (If any):

Person's Name: _____ Phone: _____
Person's Address: _____ City: _____ State: _____ Zip: _____

Their Auto Ins. Co. Name: _____ Their Ins. Co. Phone: _____ Ext: _____
Their Ins. Co. Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Claim #: _____Name of Their Insurance Adjustor: _____

_____	_____	_____	_____
Signature	*Relationship (self, parent, guardian)*	*Printed Name*	*Date*