Judith K. Crabtree WHNP
Perfect Balance Center for Health and Hormonal Excellence
2420 Sonoma Street Suite A
Redding CA, 96001
(530) 227-3206
Fax (530) 605-4204
Perfectbalance2632@gmail.com

Welcome to our Office!

You will be treated with respect, and you will be expected to participate in your healthcare. What this means is that you will take the responsibility for knowing and following our office policies, to ask questions for further clarification, and to treat the staff with the same respect with which we will treat you. If you are having an emergency after hours or on days that I am not in the office and my assistant can't assist you, you may be asked to go to a walk in clinic or the hospital for your urgent needs.

With my new office there have been a few changes one of those being my inability to bill your insurance. Payment is due at the time services are rendered and the fee schedule is as follows. A 30 minute appointment will be $135.00. One hour and New patient appointments are $260.00. Due to the change in billing practices with our new office we were required to OPT out of Medicare. What this means to you as a Medicare patient is that we are unable to bill Medicare and due to our inability to bill Medicare you as the patient are unable to bill Medicare as well. If you cannot keep a scheduled appointment please call us 24 hours prior to your scheduled appointment to avoid a $50.00 missed appointment fee.

The office prescription refill policy is as follows:

Please allow 3 business days for the pharmacy and office to process your prescription refill. Please contact your pharmacy for refills; they will contact the office by fax. Please remember that the office hours may change around the Holidays. Remember to check for needed refills in plenty of time so you do not run out of your medications. If you do run out and the office is closed, you will need to visit a local walk in clinic for a temporary refill until the office can process your refill requests. Please take note that there will now be a $15.00 fee to complete a Prior Authorization. This is due to the time consumption to complete. Thank you for understanding.

I will be utilizing the Hospitalist Service at both Shasta Regional Medical Center and Mercy Medical Center in Redding. What that means for you is that the physician on call in the hospital will be admitting and following you in the hospital if admission is needed. This will ensure you are not waiting on me in the hospital and patients in the office can be seen without delay.

Most patients know what their insurance will cover. Please remember there is no way for me to know what each individual plan will cover. The decisions I make are for your health care. It is your responsibility to make sure BEFORE you have tests done, that the tests will be covered by your insurance or that you will be responsible. I make decisions based on medical necessity, not insurance coverage's.

Again, Welcome to the office we look forward to working with you for all your hormonal needs!

Judith K. Crabtree M.P.

Judith K Crabtree WHNP

I understand these office policies and will not hold the Nurse Practitioner responsible if she is unable to see me.

_____ Date Signed: _____

Patient Signature

REGISTRATION

Name-First Middle Last	Social Security #
Street Address City State Zip	Date of Birth
Home Phone # Work Phone # Cell Phone #	Marital Status
Employer and Employer Address	Occupation
Referred By	Gender

Partner Information

Name-First Middle Last	Social Security #
Street Address City State Zip	Date of Birth
Home Phone # Work Phone # Cell Phone #	Marital Status
Employer and Employer Address	Occupation
Referred By	

Next Of Kin

Name	Relationship
Home Phone #	Address

Insurance Information

Primary	Secondary
Insurance Company Name	Insurance Company Name
ID# Group #	ID# Group #

Responsible Party

Name	Relationship	Home and Cell #
Address		

Preferred Language	
Race	
Ethnicity Please Circle One	**(Hispanic or Latino) (Not Hispanic or Latino) (Patient Declined to Specify)**
Cell Phone Number that we can send text Notifications of Appointments.	
Email Address to send email appointment confirmations.	
Preferred Method Of Communication	**(Home #) (Cell #) (Work #) (Text) (US Mail) (Email)**

FAMILY AND FRIEND ACCESS FORM

In order to communicate your health status, or permit any uses or disclosures of protected health information (PHI), to patient identified Family and Friends, we will need your permission.

☐ I request the following individuals to have access to my PHI.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Guardian Signature/Relationship Date

Our Policy is a patient must cancel or reschedule their appointment a minimum of 24 hours prior to their scheduled appointment. Failure to do so will result in a $50.00 missed appointment fee. This must be paid prior to the next scheduled appointment. Please, feel free to leave a message on our machine with scheduling regarding canceling an appointment if after business hours.

I have read, understand and will comply to the best of my ability to the above patient responsibility information and the missed appointment policy.

Print Name_____

Signature_____

Date:_____

PATIENT'S RIGHTS

1. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment care.
2. Considerate and respectful care
3. Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of other physicians and non-physicians who will see the patient.
4. Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand
5. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significantly risk involved in this treatment, alternate courses(s) of treatment or non- treatment and the risk involved in each and to know the name of the persons who will carry out the procedure or treatment.
6. Participate actively in decisions regarding medical care. To the extent permitted by law, this includes the right to refuse treatment.
7. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence.
8. Confidential treatment of all communications and records pertaining to the care and stay in the hospital. Written permission shall be obtained before the medical records can be made available to anyone not directly concerned with the care.
9. Reasonable responses to any reasonable requests made of service
10. Leave the hospital even against the advice of physicians
11. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of persons providing care.
12. Be advised if hospital/personal physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate I such research groups.
13. Be informed of continuing health requirements following discharge of hospital
14. Examine and receive an explanation of the bill regardless of source of payment.
15. Know which hospital rules and policies apply to the patients conduct while a patient
16. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
17. Designate visitors of his/her choosing, if the patient has decision-making capacity, whether or not the visitor is related by blood or marriage unless:
    - No visitors are allowed
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitors to the health facility, or would significantly disrupt the operations of the facility.
    - The patient has indicated to the health facility staff the patient no longer wants this person to visit
18. Have patient's wishes considered for purposes of determining who may visit if the patient lacks decision-making capacity and to have the method of that consideration disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any person living in the household.
19. The section may not be construed to prohibit a health facility from otherwise establishing reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

Patient's Responsibility information

We at Perfect Balance Center for Health and Hormonal Excellence care about you. In an attempt to provide the best services to all of our patients, we ask that you help us by:

1. Being on time for your scheduled appointments.

2. Canceling your appointments with at least a 24 hour notice.

3. Maintaining a clean, quiet, safe environment while at our office.

4. Supervising your children (running climbing, yelling, etc. is not allowed)

5. Please take note that we are no longer able to bill your insurance the fee for your visit is as follows we will give you a superbill to submit to your own insurance company for reimbursement.

- 1 Hour Appointment or New Patient Visits- $260.00
- 30 Minute appointment- $135.00
- Class for DNA test results- $65.00 for the class and time spent to go over your results.
- 15 Minute appointments are available for **Medicare patients only** for $75.00 once a year this is an abbreviated appointment so if you need to discuss multiple conditions this would not be an option for your appointment.

6. Bring all of your medications to each visit for Judith to review and refill.

7. Please keep us updated on any change. (Name, Address, Phone Number, Health Conditions, Family Situations, or anything else that you feel would aid us in providing you with excellent health care).

8. Please fill out completely the enclosed medical history form and family health history.

9. Communicate verbally or in writing any concerns that you have to a staff member or myself.

10. Not smoking in the facility or in front of the facility.

11. Proving to the best of your knowledge, accurate and complete information about the present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.

12. Being responsible by communicating clearly and understanding the direction for your care.

13. You are responsible for your actions if you refuse treatment or if you do not follow Judith's instructions.

14. Please be respectful of the property of other people and the office.

15. NO use of Cell Phones in the office.

16. Requesting medication refills from your pharmacy at least 72 hours prior to running out of your medications as your health care provider or staff may not be in the office daily. We are closed on Fridays, Weekends and Major Holidays.

17. Judith may make suggestions for certain tests and labs at her discretion to determine the best treatment alternatives. You are responsible to contact your insurance company to determine benefits and know coverage of your insurance plans.

Notice of Privacy Practices

HIPPA (Healthcare Insurance Portability and Accountability Act of 1996) restricts collection use, and sharing of confidential medical and personal information. This information includes items such as your name, age, date of birth, telephone number, address, social security number, information about your health, work, employment, family, medication use, diagnostic data, health insurance, etc.

At the office of Judith Crabtree, we use the information obtained from you, your referring physician and other healthcare providers, insurance carriers, pharmacies, and diagnostic facilities for the purpose of:

- Scheduling for consultation and treatments at the office of Judith Crabtree and other healthcare facilities.
- Evaluation and treatment.
- Identifying a particular patient to locate him/her within our waiting room areas.
- Discussing diagnosis and treatment plan with staff.
- Discussing diagnosis and treatment plan with your family members or guardian.
- Referring you to other providers such as Consultants, Physical Therapists, Surgeons, Psychologist, etc.
- Sending reports to your attorney, insurers.
- Dictation transcribing company's use.
- Sending information to other persons or firms where you have signed a "Release of Information".

The information is stored in a paper chart and computers at the office of Judith Crabtree and is shared via fax, email, US mail, telephone, and personal communications. We share as minimal information as possible for appropriate use. Judith Crabtree does not provide, sell, or market the information to commercial firms for marketing reasons.

The HIPPA guidance clarifies that a health care provider may rely on his or her professional judgement in determining whether there is an emergency which would justify foregoing the consent requirements as is permitted by the Privacy Standards.

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Patient Consent Form

By signing this consent you are granting consent to Judith Crabtree to use, and disclose your protected health information (PHI) for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our office at (530) 227-3206.

You have the right to request us to restrict how we use and disclose your protected health information (PHI) for the purpose of treatment, payment or health care operations we are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. If you refuse to sign this consent, or revoke this consent, Judith Crabtree may refuse to treat you as permitted by section 164.506 of the Code of Federal Regulations.

You have the right to revoke this consent in writing, except to the extent we already have used, or disclosed your Protected Health Information (PHI) in reliance on your consent.

Patient Signature/Guardian Date

Printed Name of Patient/Guardian

RELEASE OF INFORMATION

In order to communicate your upcoming appointment time, we will need your permission to leave the information on a voicemail, answering machine, etc.

☐ I hereby allow my appointment information to be left for me on my voicemail, answering machine, etc.

_____

Patient Signature Date

I _____, also give my permission for the following (lab results, x-ray report results, referrals, prescriptions, mammogram results, ultrasound results, bone density results) to be left on the voicemail/answering machine of my choice.

☐ Home Phone Number _____

☐ Work Phone Number _____

☐ Cell Phone Number _____

☐ Other Phone Number _____

This authorization is effective until rescinded by myself in writing.

_____

Patients Signature Date

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I hereby authorize _____

Phone_____ Fax _____

To release medical records and information of the following patient to

_____

Patient Name: _____

Address:_____

_____

Phone Number: _____

Date of Birth: _____

Records Requested:

All Records _____ Labs_____ Other _____

All information about the care and treatment of the above named patient may be released, including but not limited to information about general medical care, outpatient treatment with a psychotherapist, and substance abuse/ chemical treatment, unless specific restrictions are listed below.

Restrictions: _____

Disclosure of records/ information may be used only for the purpose of patient care.

_____

Patient Signature Date

If form is not signed by the patient please indicate relationship of signer: _____

This Authorization expires on: _____

_____ I am aware there may be a charge for this service as governed by the California Health and Safety Code # 123110