Frontier Health and Wellness, LLC (on behalf of its Contracted Providers)

Consent to Treat and Consent to Financial Responsibility

_____ **(Initial) Guarantee of Outcomes**. By initialing here, you recognize that no guarantee of a specific outcome/report has been provided. Payment for services does not guarantee or imply specific results from any services provided. This includes but is not limited to testing scores, treatment plan recommendations, assessments and diagnostic evaluations administered and/or completed by a Frontier Health and Wellness (FHW) contracted provider.

_____ **(Initial) Split Custody/Guardianship**. If a patient is a minor, and legal custody is not split 50/50 between guardians or a patient is over the age of 18 but has a legally appointed guardian FHW WILL REQUIRE A COPY of the custody/guardianship documentation from the court. FHW providers request involvement of both parents/guardians within the limitations of the legal custody/guardianship documentation. Please note, that the default position of any provider is to assume 50/50 legal and physical custody/guardianship unless legal documentation is provided. Disclosure of a patients given custody/guardianship status, if it is anything other than 50/50, or a patient over the age of 18 is their own legal guardian, is the responsibility of the parent/guardian.

By initialing here, you are confirming that:

_____ **(Initial)** You are your own legal guardian or that you are guardian of the patient being referenced here,who is over the age of 18, and have provided FHW with all the appropriate legal documentation confirming your guardianship.

OR

_____ **(Initial)** You share 50/50 legal and medical custody of the patient or legal/medical custody is not equally shared between parents and you have provided FHW with all the appropriate court appointed custody documentation.

___ **(Initial) Assignment of authorization to negotiate on your behalf regarding Insurance Benefits and Payment.** By initialing here, you authorize your health insurance provider(s) to directly pay your FHW Contracted Provider(s) any benefits due under the terms of your health care plan(s), for services rendered by your FHW Contracted Provider(s). You hereby permanently assign, handover and set over to FHW and its Contracted Providers all your 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 you for any/all services rendered by FHW Contracted Providers in the interim of the claim for care provided by the FHW 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 FHW or its Contracted Providers to pursue any such right of reclamation. You authorize any and all of your health insurance provider(s) or tertiary client(s) to directly pay FHW Contracted Providers all reimbursements due for services received.

_____ **(Initial) Assurance of Compensation**. By initialing here, you understand and agree that payment for services rendered by your FHW Contracted Provider(s) is ultimately your financial responsibility and will be paid. You agree (whether signing as a guarantor or as a patient), that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account of your FHW Contracted Provider(s) in accordance with the regular fee scheduled and terms of each of FHW Contracted Providers within 30 days of receiving your statement/invoice. You agree that you have been given the opportunity to review your providers fee schedule(s)/rate(s) for services. You agree that you have had all your questions answered regarding possible charges for services rendered by your FHW Contracted Provider(s) and that you will pay the charges that accrue for said services.

Should your account be referred for collection by an attorney or collection agency, you agree to pay in full, the amount not referred for collection by an attorney or collection agency. You agree to pay all the total amount not paid when within 30 days of receiving your statement/invoice.

If legal custody/guardianship is shared (to included medical treatment costs) FHW and its Contracted Providers will require one parent/guardian to be the primary contact/guarantor for any contact regarding billing purposes.

_____ **(Initial) Medicaid/Denali KidCare/Medicare**. By initialing here, you acknowledge that you have been informed that services rendered at FHW through an FHW Contracted Provider cannot be billed to **Alaska Medicaid, Denali KidCare or Medicare Insurance Plans.** You understand that the financial responsibility for any/all services rendered that is not covered by your commercial medical insurance plan (NOT TO INCLUDE Alaska Medicaid, Denali KidCare or Medicaid) cannot be billed to Alaska Medicaid, Denali KidCare or Medicare. Any/all remaining balances will be your financial responsibility to be paid in full within 30 days of receiving your statement/invoice.

_____ **(Initial) Court/Legal Proceedings.** FHW and its Contracted Providers provide clinical care and do not conduct Forensic or Custody Evaluations. If requested, FHW Contracted Providers will independently choose whether they will take part in requested court proceedings and/or legal matters. By initialing here, you are agreeing that you, nor your representative(s) will subpoena FHW or its Contracted Providers for matters related to personal court proceedings and/or legal cases.

_____ **(Initial) Cancellation Policy and Agreement.** Appointments must be canceled within 2 business days or more to avoid a late cancellation/no show fee. Cancellations can be provided via email to contact@FHWAK.com, or a voicemail message on the FHW voicemail, each of which are time stamped for verification. Accruing 4 or more no-showed appointments/late cancellations within a rolling calendar year may result in termination of the patient/provider relationship. If you no-show or provide a late cancellation two or more initial intake appointments, you may be removed from the FHW Contracted Provider's services/schedule.
The fee for a late cancellation or no-show is decided independently with each FHW Contracted Provider. These fees range from $50.00 to 100% of the appointment cost but for specific charges, please consult your provider directly. Please know that insurance companies do not cover missed appointment fees and the accumulated balance will be your sole financial responsibility.

____ **(Initial) Confirmation Calls.** Confirmation/Reminder calls, emails and or text messages are a courtesy that FHW may provide on behalf of its Contracted Providers. The absence of a confirmation/reminder call, email and/or text does not invalidate the ***Cancellation Policy Agreement.***

_____ **(Initial) Medical Record Requests**. FHW staff will work with our Contracted Providers to manage all incoming medical records requests. Each request will be completed in accordance with State of Alaska Statues which allow a provider 30 days after the valid request is received to complete it.
Record requests from health care facilities, mental health clinics, hospitals, academic centers, and other related institutions will require a completed and signed FHW 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. Please note that court orders do not require a release of information from the patient or parent/guardian.

____ **(Initial) Mental Health Emergencies.** If you are ever experiencing a psychiatric/psychological emergency (e.g. harm to self or others), you are instructed to call 911 or, if able, go to The Providence Psychiatric Emergency Room in Anchorage; 3200 Providence Drive Anchorage, AK 99508. FHW 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.

_____ **(Initial) Electronic Communication and Phone Contact.** Electronic communication; whether through email or the FHW website; 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.** 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 FHW provider information page or the FHW website for information on each provider's individual entity. Frontier Health and Wellness is not a medical or clinical provider and all clinical decision making occurs outside of the authority of FHW. Furthermore, all diagnostic and treatment decisions exist between patient and provider and do not in any way involve FHW or its employees.

_____ **(Initial) Informed Consent for Telehealth Services**. You authorize FHW's Contracted Providers to provide treatment and diagnostic assessment via a telehealth platform and that you understand and agree to the following:
The laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies you will be disclosed to researchers or other entities without your consent.

- You have the right to withhold or withdraw your consent to the use of telehealth during your care at any time, without affecting your right to future care or treatment.
- You understand that you have the right to inspect all information obtained during a telehealth interaction and may receive copies of this information.
- You understand that you may still be expected to pick-up a hard copy of my medication prescription if the medication I am being prescribed is mandated by the DEA to be delivered direct to the pharmacy.

_____ **(Initial) Medication(s) and Refill Policy.** If you need a refill on a medication that you have previously been prescribed from your FHW contracted provider they must be must be requested directly through FHW or your provider. FHW contracted providers cannot honor pharmacy requests due to the inconsistency and inaccuracy of patient medication information. To request a refill please visit the refill request page at FHWAK.com. The Refill Request form must be completed IN-FULL for the provider to process it. Refill requests can also be by phone by calling the FHW prescription refill line at 907-222-6606 option 3. Requests can be sent via email, but these are often delayed as necessary pieces of information are not always included.
Refill requests can take up to 3 business days to process (Saturdays, Sundays and holidays are not considered "Business days" when calling in for refills).
It is the responsibility of the patient/guardian to notify their provider of any other newly prescribed medications or treatments when requesting a medication refill. This is for the safety of the patient to try and avoid any medication reactions that may occur.

_____ **(Initial**) **Access to Pharmacy Claim and Medication History.** By initialing you hereby agree to allow FHW staff and its contracted providers to access your pharmacy claim and medication history in real time through SureScripts. You are authorizing your provider OR an authorized agent working on behalf of FHW to view your pharmacy claims and medication history. This will contain prescriptions and claims that have been submitted by other providers that are not affiliated with FHW. You have the right to revoke this consent at any time. Please submit in writing your desire to revoke consent for FHW and its contracted providers to access your pharmacy claims and medication history.

_____ **(Initial) COVID-19 Virus.** You will follow all Federal, CDC, State of Alaska and Municipality of Anchorage guidelines and mandates regarding the containment of the COVID-19 Virus. You understand that FHW and its contracted providers reserve the right to refuse face-to-face services if you or anyone you have been in close contact with has been/is currently ill or is experiencing symptoms of the COVID-19 virus. You understand that if any member of the FHW staff or one of its Contracted Providers is ill or experiencing symptoms of the COVID-19 virus your regularly scheduled face-to face appointment may be moved to a telehealth appointment or cancelled to maintain the health and safety of all patients.

Acknowledgment 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 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.

_____	_____	_____
Patient Name	Patient Date of Birth	Date

_____	_____
Patient/Guardian Signature	Guardian Name (if applicable)

Frontier Health and Wellness, LLC Contracted Providers

E. David Hjellen D.O. – Frontier Health Services, Child, Adolescent and Adult Psychiatry
Spencer Augustin D.O., – SRA D.O., LLC, Child, Adolescent and Adult Psychiatry
Victoria Swatek MS, LPC, CATP – Beyond Barriers Counseling, Child, Adolescent and Adult Clinical Therapy
Olivia Harris, Psychiatric Mental Health NP – Olivia Harris, LLC, Adult Psychiatry