Harmony Health of WNY

1379 W Ridge Rd.
Rochester, NY 14615

Phone: 585-684-3556 | Fax: 585-360-1701 | christine@harmonyhealthwny.com | www.harmonyhealthwny.com

Authorization to Release Healthcare Information

Patient's Name:	Date of Birth:
Previous Name:	Social Security #:
I request and authorize the following Medical Provicer to release healthcare information of the patient named above to:	Dr. Mark Sarnov, MD c/o Harmony Health of WNY 1379 W Ridge Rd. Rochester, NY 14615

Previous Physician/Office: ______________________________

Address: ______________________________

Phone: ____________________ Fax: ____________________

This request and authorization applies to:

◯ Healthcare information relating to the following treatment, condition, or dates

◯ All healthcare information ◯ Other

[List here]

[Additional information]

DECLARATION

◯ Yes ◯ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

◯ Yes ◯ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________________ Date signed:

THIS AUTHORIZATION EXPIRES ONE HUNDRED AND EIGHTY DAYS AFTER IT IS SIGNED.

Harmony Health of WNY
NEW PATIENT FORM

DATE ___________________ ACCOUNT # ________________

PATIENT INFORMATION

Last Name ______________________________________
First Name ______________________________________
Address ____
City ____________________ State ______ Zip __________
Home Telephone _________________________________
Cell Phone ______________________________________
Employer _______________________________________
Email ____

Date of Birth _____________________ Age ____________
Social Security # __________________________________
Driver's License # _________________________________
Emergency Contact _________________________________
Telephone ______________________________________
Address ____
_________________________________ Apt. # ________
City ___________________ State ______ Zip __________
Who referred you to us? ____________________________

Race: ❑ American Indian ❑ Asian ❑ African-American ❑ Alaska Native
❑ Native Hawaiian or other Pacific Islander ❑ White ❑ Other

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Sex: ❑ Male ❑ Female ❑ Transgender

POLICY HOLDER INFORMATION (if patient is not policy holder relationship to policy holder ___________)

Last Name ______________________________________
First Name ______________________________________
Address ____
City ____________________ State ______ Zip __________
Home Telephone _________________________________
Spouse's Name __________________________________

Social Security # __________________________________
Employer _______________________________________
Cell Phone # ____________________________________
Message Phone # _________________________________
Date of Birth ____________________________________
Driver's License # _________________________________

INSURANCE INFORMATION

Please enter information about the **POLICY HOLDER (if patient is not policy holder)**

Insurance Company ______________________________
Group Number ___________________________________
Insurance ID # __________________________________
Owner of the Policy ______________________________
Insurance Company Address ________________________
____

Ins. Phone # _____________________________________
Employer _______________________________________
Relationship to Patient ____________________________

Is this a work related injury or motor vehicle injury? _________

Managed Care Programs: If I am or become a member of an affiliated managed care program, I understand that it is my responsibility to know the limits and benefits of my plan. If I accept health services that are found by my plan to be "non-covered", I agree to promptly pay the customary charges for these services.

I hereby authorize the release of medical information to my insurance company(s), and assign benefits otherwise payable to me to Harmony Health of WNY. A copy of this is as valid as the original. I understand that payment is due at the time of service, and I am totally responsible for my charges.

Signature ____ Date ____________________

(over)

Consent to Treat

I voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by the physicians of **Harmony Health of WNY**, their staff and designees, as may in their professional judgement, be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

____ Initial

PHI Consent

I consent to the use or disclosure of my protected health information by **Harmony Health of WNY** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Harmony Health of WNY**

____ Initial

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Harmony Health of WNY** is not required to agree to the restrictions that I may request. However, if **Harmony Health of WNY** agrees to a restriction that I request, the restriction is binding on **Harmony Health of WNY** and the **physicians of Harmony Health of WNY**

____ Initial

I have the right to revoke this consent, in writing, at any time, except to the extent that the **physicians of Harmony Health of WNY** or **Harmony Health of WNY** has taken action in reliance on this consent.

____ Initial

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information my identify me.

I understand I have a right to review **Harmony Health of WNY** Notice of Privacy Practices prior to signing this document. The **Harmony Health of WNY's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Harmony Health of WNY.** The Notice of Privacy Practices for **Harmony Health of WNY** is also provided in the reception room of the Practice. This Notice of Privacy Practices also describes my rights and the **Harmony Health of WNY's** duties with respect to my protected health information.

____ Initial

I have been given the Harmony Health of WNY Practice Notice of Privacy Practices for review.

____ Initial

______________________________ ______________________________

Signature of Patient of Personal Representative **Date**

______________________________ ______________________________

Name of Patient or Personal Representative **Description of Personal Representative's Authority**

Please list people with whom we can discuss your care and leave messages.

1)__________________________ Relationship to Pt ____________ Ph #__________________________

2)__________________________ Relationship to Pt ____________ Ph #__________________________

May we leave a message regarding your care on your answering machine? ( ) Yes ( ) No
May we leave a message regarding your care on your cell phone? ( ) Yes ( ) No
May we text you a message on your cell phone regarding your care? ( ) Yes ( ) No

(please understand that if we cannot leave messages, it will be your responsibility to initiate contact with us regarding follow-up of lab appointments, etc.)

Harmony Health of WNY Financial Policy

Our priority is to provide exceptional medical care to our patients.
We value our relationship with you. Please read this financial policy carefully to prevent misunderstandings.
Thank you.

1. It is your responsibility to keep the practice updated with your most current information (insurance, address, phone numbers, emergency contacts, etc).
2. Any questions regarding benefit issues or physician participation status should be directed to your insurance company. We will help with what we can but we don't know each contract and its benefits
3. We expect any copay to be paid at the time of service. If payment is not made at the time of the service a $10 administrative fee will be added to your account. It is part of your contract with your insurance for you to pay your copay at the time of service
4. We are collecting partial payment for the high deductible insurances at the time of your visit. We will bill you for any remaining balance after your insurance processes your claim. We make every effort possible to determine what is allowed by your insurance. We realize there could be a conflict with your HSA or FSA account if an over payment is made. Please be aware of your deductible status
5. We will file a claim on your behalf to all insurers with whom we are currently participating. If we are not participating with your insurer, you are responsible for paying in full at the time of service. We do not participate with all insurers so please check with your insurance to verify that you are covered here. Some insurers require you to list a Primary Care Physician (PCP). Please make sure one of our doctors is listed so they will pay for your visit here.
6. Many offices do not bill a secondary insurance company, but we will bill most secondary insurances as a courtesy to our patients. Please make certain you have all your current insurance information available at check in so we are able to provide this service. We will not submit for a copay in many instances.
7. We will submit for motor vehicle accident (MVA) claims but we do not submit for Workers' Compensation or any liability claims. We do not treat workers' compensation injuries, therefore, we refer you out to someone who does
8. There is an administrative charge of $25 for the completion of forms that require a provider to review your chart and sign the form. This fee is waived if the form is presented at the time of a scheduled appointment.
9. Returned checks will incur a $30 returned check fee. In the event of a second returned check, your privilege to pay by check on future visits will be terminated and you will be expected to pay with cash or credit card.
10. We require prior notification (minimum of 24 hours) if you are unable to keep your appointment. There will be a $75 charge for all missed appointments ($100 for complete physical exams).
    Chronic missed appointments could result in termination of care.
11. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, the patient will be fully responsible for any cost, including, but not limited to attorney's fees. If there is no response to our continued efforts to reach the patient by phone or mail the patient will be told to seek medical care elsewhere. We work very hard to help you keep this from happening. Please keep in touch with us if there is a financial hardship.
12. We require that you sign a payment plan agreement if you are unable to pay the entire balance on your account by the due date. The amount paid each month will be determined by Harmony Health of WNY and must be paid in addition to any additional charges each month. It is your responsibility to make the monthly payment on time without additional reminders.

Signature: ____ Date: ______________________

Print Name: ____

Harmony Health of WNY
1379 W Ridge Rd. Rochester, NY 14615
Phone: (585) 684-3556 | Fax: (585) 360-1701

Last Name: ____________________First Name: ___________________Middle Name: ___________

Date of Birth:__________________Gender: Male/Female:___________ Marital Status: ___________

Address: Street/Apt: ____

Town/City: ________________________________State:______________ZipCode: ______________

Best phone Number(s): ____________________________Work: ____________________________

Email: ____

Health Insurance Information

1. Company:_____________Policy #_________________Name of Primary Holder________________

2. Company:_____________Policy #_________________Name of Primary Holder________________

Emergency Contact: Name/Relationship phone number:

1. ____

Previous Primary Physician and Phone Number: ____

Specialists(Name and Specialty): ____

Education: Completed Grade:____________ College/Trade PostGrad Doctorate

Occupation: ____

Do you currently have or had in the past any of the following: (Please Circle)

Diabetes	Cancer	Stroke	Psychiatric care
COPD	Heartburn/ reflux	Heart Murmur	Hernia
High cholesterol	Seizures	Headache/Migraine	Liver problems/ Hepatitis
Asthma	Sexually Transmitted Infection	Arthritis	Ulcers/ Colitis
High blood pressure	Anemia/ blood or bleeding problems	Neurological problems	Prostate problems
Chest Pain	Heart Disease	Thyroid problems	Eating disorder
Kidney/bladder problems		Anxiety/ depression	Sinus problem/ Seasonal allergies
Low blood pressure		Corrective lenses/ glasses	

Are you a smoker? Yes No If Yes, how long? ____________________

Do you drink any alcohol? Yes No If Yes, how much per day? ____________________

Recent Hospitalizations:

____

Number of Pregnancies:______Deliveries: ______ Miscarriage/Termination:______ Living:______

Surgical Procedures you have had:

Type	Hospital/Surgicenter	Date

Provide Additional Page If needed

Family History: (Please list medical issues in your relatives)

Mother:________________ Mother's Mother: _____________ Mother's Father: _____________

Father:________________ Father's Mother: _____________ Father's Father: _____________

Sister 1:________________________________ Sister 2: ________________________________

Brother 1:_______________________________ Brother 2: _______________________________

Daughter 1:______________________________ Daughter 2:______________________________

Son 1: _________________________________ Son 2: _________________________________

Maternal Aunt:___________________________ Paternal Aunt: ___________________________

Maternal Uncle:__________________________ Paternal Uncle: __________________________

Health Maintenance (Most Recent):

EyeExam: ____________________________________

Mammogram: __________________________________

Colonoscopy: _________________________________ Pap smear: _________________________

Dental: ______________________________________ Dexa/ Bone density: __________________

PSA: ____

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Preferred Pharmacy:

1. Local: ____

2. Mail order: ____

Medication	**How much**	**How often:**

Provide Additional Page If needed

Do you have any **Allergies** (medicine or otherwise) Circle: **Yes** **No**

Allergies	**Reaction**

Provide Additional Page If needed

HIPAA Omnibus Notice of Privacy Practices

June 2021 Version 15.0000

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

- **Treatment:** We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

- **Payment:** Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

- **Health Care Operations:** We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Minors:** Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

- **Required by Law:** We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.

- **Abuse, Neglect, and Domestic Violence:** Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious

threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

- **Judicial and Administrative Proceedings:** As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

- **Law Enforcement:** We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

- **Coroners and Medical Examiners:** We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.

- **Public Health:** Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

- **Health Oversight Activities:** We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.

- **Inmates:** If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

- **Military, National Security, and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials.

- **Immunizations:** We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

- **Worker's Compensation:** We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

- **Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

- **Breach Notification Purposes:** If for any reason there is an unsecured breach of your Protected Health Information, we will utilize the contact information you have provided us with to

notify you of the breach, as required by law. In addition, your Protected Health Information may be disclosed as a part of the breach notification and reporting process.

- **Research:** Your Protected Health Information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

- **Business Associates:** We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing or transcription services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your Protected Health Information.

USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

- **Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

- **Disaster:** In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

- **Fundraising:** As necessary, we may disclose your Protected Health Information to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not disclose or use your Protected Health Information in the situations listed below without first obtaining written authorization to do so. In addition to the uses and disclosures listed below, other uses not covered in this Notice will be made only with your written authorization. If you provide us with authorization, you may revoke it at any time by submitting a request in writing:

- **Disclosure of Psychotherapy Notes:** Unless we obtain your written authorization, in most circumstances we will not disclose your psychotherapy notes. Some circumstances in which we will disclose your psychotherapy notes include the following: for your continued treatment; training of medical students and staff; to defend ourselves during litigation; if the law requires; health oversight activities regarding your psychotherapist; to avert a serious or imminent threat to yourself or others; and to the coroner or medical examiner upon your death.

- Disclosures for marketing purposes and sale of your Protected Health Information

PROTECTED HEALTH INFORMATION AND YOUR RIGHTS

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

- **You have the right to inspect and copy your Protected Health Information (reasonable fees may apply):** Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

- **You have a right to a summary or explanation of your Protected Health Information:** You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

- **You have the right to obtain an electronic copy of medical records:** You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

- **You have the right to receive a notice of breach:** In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.

- **You have the right to request Amendments:** At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your Protected Health Information. An “accounting” being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

- **You have the right to request restrictions of your Protected Health Information:** You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

- **You have a right to request to receive confidential communications:** You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You

do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. **We will not retaliate against you for filing a complaint.**

COMPLAINTS

If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services.

If you wish to file a complaint with us, please submit it in writing to our Privacy/Compliance Officer to the address listed on the first page of this Notice.

If you wish to file a complaint with the Secretary of the United States Department of Health and Human Services, please go to the website of the Office for Civil Rights (www.hhs.gov/ocr/hipaa/), call 202-619-0257 (toll free 877-696-6775), or mail to:

Secretary of the US – Department of Health and Human Services
200 Independence Ave S.W.
Washington, D.C. 20201

Christine Anello	585-684-3556	christinea@harmonyhealthwny.com
HIPAA COMPLIANCE OFFICER	**PHONE**	**EMAIL**

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information. We are also required to maintain the privacy of, and abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the number listed above.

HARMONY HEALTH OF WNY

Terminating the Physician-Patient Relationship & No-Show Policy

Policy Statement:

It is the policy of HARMONY HEALTH OF WNY ("HHWNY"), its practices and physicians/providers to maintain a therapeutic and trusting relationship with all patients. When such a relationship has not been formed or the relationship with a patient is no longer proceeding in an effective manner, the attending provider may terminate his/her relationship with the patient which would include ALL members of the patient's family and it would also include being seen by any other provider in this practice. Any such termination shall be carried out within the bounds of applicable state and federal laws, rules, regulations and professional guidelines such as the American Medical Association guidelines, and this policy. Termination of the relationship may occur with the goal of assuring appropriate continuity of care for the patient. When a patient cancels appointments, procedures or other scheduled care on a repetitive basis without cause or enough notice, quality and continuity of care are adversely impacted, office schedules are disrupted, and it impedes other patient(s) appointments. In order to decrease the incidence of such cases, a "No-Show fee of $75.00 (or $100.00 for physical exams)" may be assessed and/or, when indicated, can result in the physician/patient relationship to be terminated.

Causes for Termination

The physician or his/her designee identifies a patient with whom the physician-patient relationship has been affected negatively or is no longer therapeutic. The types of circumstances that can result in termination include, but are not limited to, the following:

- Repeated noncompliance with therapies or treatments essential to the patient's safety as deemed medically necessary by the physician or other attending healthcare provider ("Provider").
- Failure to meet financial obligations to Harmony Health of WNY regarding care provided or to cooperate with payment processes consistent with Harmony Health of WNY payment policies.
- Consistent or repeated failure to keep appointments without good cause and/or without notice of intent to cancel appointments.
- Threatening, violent, abusive or patterns or repetitive rude or offensive behavior directed at a Provider, other Harmony Health of WNY staff, or other patients or visitors.
- Attempts by the patient to use the relationship to illegally or improperly obtain controlled substances for non-therapeutic purposes, abuse of controlled substances or otherwise refusing to obtain treatment for controlled substance abuse or addiction, seeking multiple prescriptions from different physicians or diverting controlled substances.
- The patient elects to terminate or expresses a desire to terminate the relationship. It is HARMONY HEALTH OF WNY's desire to do our best to have the best applicable care for all our patient's healthcare needs so we can keep the provider/patient relationship trustworthy and respectful.

Signature: ____ Date: __________________

Printed Name: ____

Initial Version: 6/6/202, Update 03/29/2024