GUARDIAN HEALTH
HEALTHCARE REIMAGINED
300 Tamiami Trail S., Unit 1
Venice, FL 34285
Phone: (941) 303-5713
Fax: (941) 837-2661

# NEW PATIENT AGREEMENT *(03/27/2026)*

As your healthcare providers, we are committed to providing you with the best possible medical care. To achieve this goal, we need your assistance and understanding of our practice policy and procedures that effect all providers and patients.

**OFFICE HOURS: 8:00am-5:00pm Monday through Friday.**

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled appointment by phone or the online patient portal. **Missed appointments and/or last-minute cancellations may incur a $50.00 charge.** You may call our office at (941) 303-5713 or go online at www.GuardianHealthFl.com for any appointment changes.

## PRESCRIPTIONS AND REFILLS:

You are responsible for your medication and their refills. Please call the pharmacy for all refill requests. The office has a 48-hour turnaround policy regarding digital and written prescriptions. The pharmacy will notify our office of your request. Controlled medications cannot be "called in" under any circumstances.

## AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION & AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We believe that all patients deserve from us the best medical care that we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy. *Our professional services are rendered to you, not the insurance company. Therefore, payment for treatment is your responsibility.* Please read the following:

- I authorize Guardian Health to release or receive any information necessary to expedite insurance claims.
- I hereby authorize Guardian Health to bill my insurance company directly for their services.
- I authorize payment directly to my Provider of any insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree and endorse any payment I receive over to my Provider for which these fees are payable.

I understand that I am directly and fully financially responsible to Guardian Health for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgement, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay by balance in full, or there is no payment made within 90 days, it is my responsibility to pay my bill directly. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee. I have read and understand what is expected of me, the patient, in relation to any care, my insurance carriers and my financial responsibilities.

## PAYMENT AT THE TIME OF SERVICE

It is our office policy that payments are due at the time of service. If we have a contract with your insurance company, we will file with your insurance on your behalf. However, patients are responsible for all co-pays, co-insurances, deductibles, and or non-covered services at the time of service. It is also your responsibility to make sure you have a valid authorization on file with your insurance company for dates of service billed on your behalf. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the information provided to the office is the most recent insurance information and it is true and correct to the best of

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my knowledge. I will notify the office of any changes in this information. A photocopy or other reproduction of this will be as valid as original. I hereby authorize Guardian Health to furnish my insurance companies, hospitals, referring or consulting physicians and billing agents, all information with regard to my medical care. I also expressly consent to receive medical care from Guardian Health.

## ONLINE COMMUNICATION & HIPAA

Upon signing the HIPAA consent form, you agree to be solely responsible for your username and password. It is not to be shared. If you choose to share this information you are allowing that person to see your PHI (Private Health Information). By signing this form, you acknowledge and accept all of the following:

- I have been explained the details of the online patient portal. I understand them, and my questions have been answered.
- Alternative methods are available to me via (in person, mail, telephone).
- I am aware that my private health information (PHI) carries a risk to my privacy should it be compromised.
- I agree to take precautions to keep my online communication safe, including but not limited to:
  - Keeping passwords confidential.
  - Closing my computer or screen when not in use.
  - Refraining from storing PHI on employer-owned computers or phones, etc.

I agree to indemnify and hold harmless, Guardian Health, of and from any claims, losses, causes of action, damage, lawsuits, judgements, including attorney's fee and cost.

We are committed to providing quality services. Therefore, you may be contacted periodically by the business to provide feedback regarding your experience. This contact may come via text or email. By signing this document you consent to allow Guardian Health to contact you for these quality control purposes.

## HIPAA NOTICE OF PRIVACY PRACTICES

**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.**
Guardian Health adheres strictly to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at all times. The following method of operations will be used to insure privacy of a patient's Protected Health Information (PHI).

- Based on HIPAA guidelines your medical records may be transferred to another care provider upon your signed authorization. Records will not be transferred without you or your legal designee's signed authorization.
- You may review your records by scheduling a time with the office.
- After review of your records if you disagree with any of the documentation in the records you have the option of writing your own documentation to be placed in the chart.
- If an appointment with another medical provider is required, only the necessary information to schedule an appointment will be provided.
- If you elect to not allow any other member of your family access to your records you have the right to notify our office. That notice must be in writing. If you wish to provide access to your records to a designated individual, you may also provide that notice in writing.
- Our office will not provide any information about you or your medical condition to any other party other than other medical providers to whom you have been referred for treatment without your specific authorization.
- If you are chosen to be part of any research program you will be required to sign additional authorizations and releases so that your PHI may be used in the program.

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- Under the HIPAA rules, we may use the necessary PHI from your medical records to file insurance claims on your behalf. Your authorization and insurance assignment allows the practice to file insurance on your behalf.
- There will be certain circumstances where public health authorities and health oversight agencies may require a copy of your records. They are authorized under law to collect that information and we are required to furnish a copy of your PHI.
- We are required by law to protect and privacy of our patients, preventing any and all disclosure of PHI to unauthorized parties.
- We are required by law to maintain the privacy of, and to provide individuals with, this notice of our legal duties and privacy practices with regard to PHI.
- If you are on active-duty military or are called to active-duty military, under federal law we are required to supply a copy of your record.

## PATIENT RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

## LATE CANCELLATION & NO-CALL/NO-SHOW POLICY

Guardian Health is committed to providing high quality, efficient, and timely care to all our patients. If an appointment is canceled or rescheduled within 24 hours of your scheduled time, a $50 fee may be applied. There will also be a $50 charge for all “No call, No Show” appointments. Patients who are late will not be assessed the fee, though they may be rescheduled if they are greater than 15 minutes past the time of their appointment. Please make note of the person’s name that you spoke with when cancelling or rescheduling your appointment. We understand that there may be extenuating circumstances that cannot be controlled, so we will do our best to accommodate.

I hereby acknowledge receipt, understanding, and agreement with all information listed within this New Patient Agreement. I also acknowledge that these policies have been put in place for the benefit of patients, including myself, and that I commit to abiding by these guidelines whilst I am a patient of Guardian Health.

| PATIENT SIGNATURE | | DATE | |
|---|---|---|---|

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# CONSENT FOR COMMUNICATION AND/OR DISCLOSURE

I request the following alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Guardian Health. I understand that this HIPAA consent applies to ALL providers of Guardian Health. It is my responsibility to notify Guardian Health of any changes.

**Please Print (Last Name) (First Name) (Middle Initial) (Date of Birth)**

I give permission to share the following information with the person(s) listed below. Please mark yes (Y) or no (N) in the columns to the right.

**Name:**_____ **Relationship:**_____ **Appointment:**_____
**Billing:**_____
**Medical:** _____

**Name:**_____ **Relationship:**_____ **Appointment:**_____
**Billing:**_____
**Medical:** _____

**Name:**_____ **Relationship:**_____ **Appointment:**_____
**Billing:**_____
**Medical:** _____

Please note that if a person is not listed on this form, Guardian Health will not share information with him/her.

Signature below will also constitute your unrestricted agreement that medically relevant information may be left on a voicemail or other answering device that you provide to us.

| | | | |
|---|---|---|---|
| **PATIENT SIGNATURE** | | **DATE** | |
| **WITNESS SIGNATURE** | | **DATE** | |

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# REQUEST & AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)

| PATIENT INFORMATION | |
|---|---|
| NAME: _____ | PHONE #: _____ |
| ADDRESS: _____ | CITY/STATE: _____ |
| DATE OF BIRTH: _____ | ZIP CODE: _____ |

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I hereby authorize the following provider(s):

Physician: _____

Hospital: _____

Diagnostic Imaging Center: _____

to use and disclose the protected health information described below to;

Guardian Health LLC
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☐ Check here to select all below

☐ Last Office Note Including: Medical History, List of Allergies, and Medications
☐ All Imaging Reports
☐ EKG
☐ Procedure Notes
☐ Other: _____

I understand that I have a right to revoke this authorization, in writing, at any time.
I understand that a revocation is not effective to the extend that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
I understand that I have the right to (1) inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extend the state law providers greater access rights) (2) Refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority