

## \* Office Policies

### Welcome to the Ideal Neurology Clinic!

Thank you for choosing Dr. Chalfin for your neurology care! We're here to support you on this journey. Please fill out the following forms prior to scheduling your first visit.

You will need the following:

- Your insurance cards
- Your medications and supplements
- Names and contact information for your pharmacy and other doctors
- Copies of records including doctor's notes, hospital discharge summaries, laboratory studies, MRI/CT scans, EEGs, EMGs/Nerve Conduction Studies, etc.
- We are going to ask you to keep a card on file. This is required as part of our office policies to protect against no shows and minimize administrative burden. You will be able to cancel your appointment up to 48 hours before without any charge to you.

If you have any questions, do not hesitate to ask. I am looking forward to meeting with you.

Warm Regards,  
Renata Chalfin, M.D.

### Summary of Office, Financial, and Cancellation Policies

Please carefully review this agreement to ensure we are a good fit for each other.

Here is a summary of the essential points:

- **Patient Forms:** All intake forms must be completed prior to scheduling your appointment. Appointments are currently being scheduled within 1-2 weeks.
- **Patient Selection:** An evaluation by Dr. Chalfin does not ensure you will become a patient of the practice.
- **Primary Care Practitioner:** We recommend ALL patients have a PCP for preventive care, regular bloodwork, and other health maintenance.
- **Insurance and Payments:** We accept Traditional Medicare only. While we make our best attempt to estimate your out-of-pocket costs, the final charges are determined by the complexity of your case and your insurance coverage.
- **Card on File:** To secure your appointment slot and protect against no-shows, we require a credit card on file. YOU MAY SEE A HOLD ON YOUR ACCOUNT SEVERAL DAYS PRIOR TO YOUR APPOINTMENT - THIS IS TO ENSURE THERE IS A VALID CARD ON FILE AND WILL BE RELEASED ON THE DAY OF YOUR APPOINTMENT. You can make changes up to 48 hours before your appointment without charge.
- **Cancellations:** Since we do not double book our appointment slots, please give Dr. Chalfin and your fellow patients the courtesy of cancelling at LEAST 48 hours prior to your appointment. There will be a flat fee (\$300 for new patients, \$150 for follow-up visits) for late cancellations or no-shows.
- **Hours of Operation:** Our practice operates on Tuesdays through Thursdays, from 9 am to 3 pm, excluding holidays.
- **Prescriptions and Referrals:** These are provided DURING APPOINTMENTS only. There is an ADDITIONAL FEE for emergency requests outside of appointments.
- **Urgent Care:** We are not an emergency facility. If you have acute symptoms that may be life-, limb-, or vision-threatening, please seek care at your local ER.
- **After-Hours Contact:** If you need to urgently speak with Dr. Chalfin after hours, you can call her emergency line, and she will return your call as soon as possible. After hours availability is NOT guaranteed. Please reserve this service for genuine emergencies (*after* you've called 911). Nonurgent, frequent, or abusive use may result in charges, warnings, or dismissal from the practice.
- **Administrative or other Nonurgent Matters:** For non-emergent concerns, such as scheduling appointments or asking a medical question, please call during office hours to our main line. After hours, you're welcome to leave a voicemail for a callback during office hours.

# Ideal Neurology Clinic Patient Agreement

This is an Agreement between Ideal Neurology Clinic, PLLC (**Practice**), a Florida LLC located at 7280 W Palmetto Park Rd, Ste 104, Boca Raton, FL 33433, Dr. Renata Chalfin (**Physician**) in her capacity as an agent of the **Practice**, and you (**Patient**).

## 1 - Background

The Physician practices neurology and delivers care on behalf of Practice in Boca Raton, Florida. In exchange for certain fees paid by You, Practice, through its Physician(s), agrees to provide Patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement. The practice website is <https://www.ideal-neurology.com>.

## 2 - Definitions

1. **Patient.** A patient is defined as those persons for whom the Physician shall provide Services, and who are signatories to this agreement.
2. **Services.** As used in this Agreement, the term Services are those offered by Practice. This Agreement is for ongoing nonurgent outpatient neurology care. The Patient is expected to maintain a relationship with a primary care practitioner, preferably a physician (M.D. or D.O.), for preventative care, including regular bloodwork, annual exams, and referrals for health maintenance examinations such as colonoscopies. The Patient may need to visit other specialists, the emergency room, or urgent care from time to time. The Patient will be provided with methods to contact the Physician. Physician will make every effort to address the needs of the Patient in a timely manner and to be available via phone when appropriate, but Physician cannot guarantee availability and cannot guarantee that the patient will not need to seek treatment in the urgent care or emergency department setting.
3. **Outpatient.** Outpatient neurology care is defined as evaluation and management of neurological conditions that is performed outside of a hospital setting, including in-office, over the phone, or via telemedicine.
4. **Acceptance of Patients.** Practice reserves the right to accept or decline patients based upon its capability to appropriately handle the patient's neurological needs. It may decline new patients pursuant to the guidelines proffered in Section 14 (Term), because the Physician's panel of patients is full, or because the patient requires medical care not within the Physician's scope of services.

## 3 - Medicare Patients.

If Patient holds a traditional Medicare Part B policy, Patient acknowledges the following policies.

1. Claims will be submitted to Medicare.
2. Copays, coinsurance, deductibles, and any other noncovered charges are the patient's responsibility and will be paid at the time of service.
3. Medicare will send an Explanation of Benefits (EOB) to both Patient and the Practice showing what the total patient responsibility is. If Patient disagrees with the amount owed, it is Patient's responsibility to contact Medicare immediately.
4. Insurance coverage must be valid and verifiable at the time of services, or Patient will be charged the direct-pay fees.
5. Telemedicine (video) consultations will be billed in the same manner as regular office visits. Medicare may or may not cover the visit in the same manner, though.

## 4 - Non-Participation in Insurance.

Patients without Medicare Part B acknowledge the following policies.

1. Neither Practice nor the Physicians participate in any other health insurance or HMO plans except for **traditional Medicare** only.
2. Neither the Practice nor Physicians make any representations regarding third party insurance reimbursement of fees paid under this Agreement.
3. The Patient shall retain full and complete responsibility for any such determination.
4. Insurance coverage is a contract between Patient and Patient's insurance, and Patient is responsible for determining their insurance's coverage for services.
5. Patient agrees to pay for each visit according to the fee schedule.
6. Patient agrees that payment is due at the time of service.
7. Patient agrees to pay an out-of-pocket fee of \$100 for telephone calls. This fee will be charged to the credit card on file.

## 5 - Credit Card on File Policy.

Patient acknowledges that Practice requires keeping credit or debit card on file both to reserve each dedicated appointment slot, as well as a convenient method of payment for services.

1. YOU MAY SEE A HOLD ON YOUR ACCOUNT SEVERAL DAYS PRIOR TO YOUR APPOINTMENT - THIS IS TO ENSURE THERE IS A VALID CARD ON FILE AND WILL BE RELEASED ON THE DAY OF YOUR APPOINTMENT.
2. Fees charged to the credit card on file include but are not limited to visit fees, co-payments, coinsurance, payments toward deductibles, and non-covered charges such as late cancellation/no show fees, telephone encounters, and refill/form fees.
3. Patient certifies that he or she is the authorized user of the credit card supplied.
4. Patient acknowledges their credit card information is kept confidential and secure via Stripe, and only the last four digits of my credit card number can be seen by the Practice staff.
- 5.

Patient acknowledges that estimated fees will be charged at the time of appointment to the credit card on file. These are just estimates and may change at the time of insurance claim processing, if applicable. Once processed, any remaining charges will be immediately charged to the credit card on file. If there is any credit on Patient's account, a refund will be posted to the credit card on file as soon as possible.

6. With the exception of payments due at the time of service, payments to the card on file are processed only after any applicable insurance claim has been filed and processed, if applicable.
7. Patient acknowledges that out-of-pocket expenses incurred between visits will be charged to the credit card on file immediately and without warning. These expenses include but are not limited to no show/late cancellation fees, telephone encounters, refills, and forms fees.
8. Patient agrees to update credit card on file when needed. Patient will receive a statement in the event the credit card cannot be charged, and there will be a **\$25 statement fee** added.

**6 - Late Cancellation Policy.** There will be a flat charge if Patient cancels or changes their appointment less than 48 hours prior to their appointment time. \$300 fee for new patients, \$150 for follow-ups. Multiple late cancellations or no shows may result in dismissal from the practice.

**7 - Telemedicine Consultations.** Patient acknowledges that Physician will sometimes engage Patient in a telemedicine (video) consultation. Patient understands:

1. the telemedicine consultation will not be the same as a direct office visit since Patient will not be in the same room as Physician.
2. Physician assumes Patient is alone during the consultation, and Physician will not know if there are any other people in the same room, or within hearing distance, unless Patient says so, thus confidentiality may be breached.
3. There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. Physician or Patient can discontinue the visit at any time.
4. As an alternative to a telemedicine consultation, Patient can cancel and reschedule the visit for a later time or seek care from another doctor's office. Patient understands if Physician believes a direct physical examination or other testing are necessary, she will ask Patient to come in for another visit in order to complete the assessment.

#### **8 - Hospital, Emergencies, and Services Between Visits**

1. This agreement is for ongoing nonurgent outpatient neurology care, not primary, emergency, or urgent care. Physician will make reasonable efforts to be available by telephone for urgent needs and to see you as needed the next available business day that the Physician is available, **but there is no guarantee of after-hours availability.**
2. Patient may be asked to schedule an appointment if issues or questions arise between scheduled appointment times. The best way to discuss their care is in a scheduled appointment to allow for examination and enough time for discussion.
3. Practice is not an emergency facility, and if Patient has emergency needs, Patient agrees to call 911 or go to the nearest ER. Patient understands they can page Physician after hours for urgent matters, but Patient may be charged \$50 for nonurgent matters at the doctor's discretion. Patient may be dismissed from the Practice if this recurs.
4. Physician does not go to the hospital. She may recommend you go to the Emergency Room if you are having symptoms of an emergent condition or need to be seen urgently, but in that case, your care will be under the hospital doctor(s).
5. Though Dr. Chalfin will make every best effort to communicate with Patient's treating doctors at the hospital, it is ultimately Patient's responsibility to communicate the names and contact information of Physician and other members of Patient's treatment team to the ER/hospital. If Patient has questions or needs clarification while hospitalized, Patient agrees to ask the doctor, nurse, or charge nurse responsible for Patient's care in the hospital because Dr. Chalfin does not have access to hospital records and is not involved in decision-making in the hospital.

#### **9 - Results, Refill, Forms, and Paperwork Policy**

1. You agree to discuss any and all results DURING appointments.
2. You agree to request all refills at the time of visits only and that you will be provided with enough refills to last you until your next appointment. You acknowledge that if you cancel or reschedule an appointment, you may run out of medication. You agree to pay \$50 for any refill requests between appointment times, and that these refills will be honored at the Physician's professional discretion.
3. You agree to request paperwork, forms, or letters during appointments. You agree to pay the out-of-pocket fee of \$50 for any letters, forms, or other paperwork that require completion by Physician outside of scheduled appointment times. You understand that you can avoid this charge by scheduling an appointment and bringing the forms to the visit. You also understand Physician will only fill out paperwork and sign statements she agrees with.

#### **11 - Controlled Medications/Marijuana Policy**

1. Dr. Chalfin does not prescribe opiates or medical marijuana for the treatment of chronic pain, or benzodiazepines for the treatment of chronic anxiety or insomnia. She does not take over the prescribing of these medications from other physicians.
- 2.

As required by law, Dr. Chalfin reviews your prescription refill habits through the Prescription Drug Monitoring Program, even if she is not prescribing a controlled substance.

3. Dr. Chalfin communicates with prescribing physicians about your treatment plan if it is related, even if she is not also prescribing me controlled substances.
4. If such medications are required for treatment of my condition, Patient agrees to bring in medication bottles to each visit for pill counts. Random urine drug screens may also be ordered between office visits to ensure compliance. Any unwillingness to participate in pill counts or drug screens will result in discontinuation of the prescription and dismissal from the practice. Any diversion or abuse of prescribed medications will result in dismissal from the practice and reporting to authorities.

**12 - Services Practice Does Not Provide.** The following services are not offered in our office at this time, usually due to their cost prohibitive nature for such a small size practice. These may change in the future. Practice will make an effort to help you obtain needed services elsewhere in the most cost-effective manner possible.

1. In-Office Procedures
2. Laboratory Studies and blood draws
3. Electrocardiograms (ECGs)
4. MRIs, CTs, USs, and other imaging studies
5. Electroencephalograms (EEGs)
6. Sleep studies
7. Dispensing medications
8. Pathology studies
9. Radiology studies
10. Vaccinations
11. Hospital Services. Due to mandatory "on call" duties required at local institutions; we have elected NOT to obtain formal hospital admission privileges at this time. See Section 9 for more information.

**13 - Term.** This Agreement will commence on the date it is signed by the Patient and Physician below and will extend indefinitely thereafter or until either party terminates the Agreement. Notwithstanding the above, both Patient and Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination. The Patient may terminate the agreement with twenty four hours prior notice, but the Practice shall give thirty days prior written notice to the Patient and shall provide the patient with a list of other Practices in the community in a manner consistent with local patient abandonment laws. Examples of reasons the Practice may wish to terminate the agreement with the Patient may include but are not limited to:

1. The Patient fails to pay applicable fees.
2. The Patient has performed an act that constitutes fraud.
3. The Patient repeatedly fails to adhere to the recommended treatment plan, especially regarding the use of controlled substances.
4. Patient makes threats or directs any aggressive or violent behavior toward staff, other patients, or neighboring businesses, or presents an emotional or physical danger to the staff or other patients of Practice.
5. Practice discontinues operation; and
6. Practice may terminate a patient without cause as long as the termination is handled appropriately (without violating patient abandonment laws).

**14 - Privacy & Communications.** Practice abides by federal privacy regulations and keeps Patient protected health information (PHI) confidential. Information will only be shared with Patient's verbal or written permission. Exceptions to this include for the purposes of treatment, payment, or healthcare operations, as well as if you are a danger to yourself or others; and if Practice or Physician are obligated to comply with an investigation. You can request a digital copy of your records at no charge, and they will be shared with you via our secure, online password-protected patient portal through Elation. You further acknowledge that communications with the Physician using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. You agree to use the online, password-protected patient portal through Elation for any general, non urgent questions. The practice will make an effort to secure all communications via passwords and other protective means. The practice will make an effort to promote the utilization of the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including email, may be made available to the patient. If the Patient initiates a conversation in which the Patient discloses "Protected Health Information (PHI)" on one or more of these communication platforms, or specifically requests release of information on one or more of these platforms, then the Patient has authorized the Practice to communicate with the Patient regarding PHI in the same format.

**15 - Attorneys.** In the event Physician is required to retain an attorney or to appear in court, the current hourly rate, billed by the quarter hour or fraction thereof, will be charged based on the most recent Attorney Fee Schedule, which can be obtained upon request.

**16 - Severability.** If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

17 - **Assignment.** This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient.

18 - **Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Florida and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice address in Boca Raton, Florida

19 - **Updates.** We will update these policies from time to time. You may review the latest policies on request.

## Appendix of Charges

### Summary of Fees for Non-Medicare (DIRECT PAY) Patients

The following fees include a discount for payment at the time of service.

- New patient appointment (direct pay).....\$500\*
  - (Discounted fee of \$250 for a shortened visit for patients < 25, college students, and school teachers).
- Follow-up patient appointment (direct pay).....\$250\*
  - (Discounted fee of \$125 for a shortened visit for patients above)
- Housecall.....+\$200 add-on fee
- Telephone visits (10 min).....\$75
- Cancellation within 48hrs of appointment.....\$300 for new patients, \$150 for follow-ups
- Between-visit refill fee.....\$50
- Between-visit form or paperwork fee.....\$50
- Nonurgent after-hours page penalty.....\$50
- Statement fee for declined Credit Card.....\$25

\* Patients with Medicare have their own rates as determined by Medicare; their responsibility will be noted in their Explanation of Benefits (EOB).

### Medicare Patients are usually responsible for the following fees

- 2024 Part B **Deductible** (before any Part B benefits are paid by Medicare): **\$240**
- After the deductible is paid for the year, **20% coinsurance**: 20% of the allowable charge for each visit or fee billed, depending on the level of complexity of the visit. For example, for a Dementia Care visit, the allowable charge is approximately \$280, of which you would be responsible for 20% which is \$56. These allowable charges change yearly.
- There is no flat copay fee for visits with traditional Medicare Part B.
- *If you have a secondary plan such as United American Plan F:*
  - Your secondary plan may pay some or all of your Part B Deductible and your 20% coinsurance.
    - However, your secondary plan may have a deductible of its own before its benefits kick in.
    - It may require a copay of its own for each visit.
  - If it is an official Medigap plan (titled Plan A, B, F, etc), you can look up the plan type and what it covers online, and we will do our best to estimate your responsibility.
  - If it's not an official Medigap plan, it is your responsibility to know your benefits, and you may need to fight for reimbursement from your secondary insurance company yourself.
  - Our practice will charge you up-front for any estimated patient responsibility. However, these are just estimates.
  - Any change to the actual amount of your Patient Responsibility will be settled to your credit card on file once the insurance's Explanation of Benefits is posted.

## Patient Acknowledgements

Please check each of the following that you understand and consent to.

This Agreement is for ongoing nonurgent outpatient neurology care. I have a Primary Care Practitioner (PCP) for preventive care.

I understand.

I do NOT expect the practice to file or fight any insurance claims on my behalf except Traditional Medicare Part B only.

I understand and agree.

I agree to place a credit card on file to pay for fees due. I agree to the Practice charging all fees to the credit card on file at the time of service.

I agree.

I agree to the Late Cancellation Policy, including a fee of \$300 for new patients and \$150 for follow-ups for cancellations within 48 hours of an appointment.

I agree.

I understand there is no guarantee of after-hours availability.

I understand.

I agree to receive results, ask for refills, request letters or referrals, and fill out any paperwork during visits only, or I will be subject to additional fees.

I agree.

I do NOT expect the practice to prescribe chronic controlled substances on my behalf. (These include commonly abused opioid medications, benzodiazepines, and stimulants.)

I agree.

I am signing this agreement and seeking neurology care from this practice voluntarily and because I believe Dr. Chalfin and Ideal Neurology Clinic are a good fit for my needs.

I agree.

**I agree to ALL of the above office policies. I understand I have the choice to seek care elsewhere if I do not agree to any of the above policies.**

The undersigned, as patient or guardian of patient, authorizes Dr. Chalfin to evaluate the patient and provide treatment. I authorize release of medical information that may be necessary for continuity of care, for reimbursement from insurers, and as needed for investigations. I assign all medical benefits payable for services to the Ideal Neurology Clinic, PLLC. I permit a copy of this authorization to be used in place of the original. I have reviewed, accepted, and will comply with office policies. I have received the privacy practices. I accept financial responsibility for all charges regardless of insurance, except where prohibited by law.

Patient or Guardian Signature

Date

\_\_\_\_\_  
Name of Signer

\_\_\_\_\_  
Relationship to Patient