# Controlled Substance Policy

Our office is not accepting new patients for the treatment of the following:

- Chronic use of narcotics (opioids medications used for pain management)
- Chronic use of benzodiazepines (typically used for anxiety, stress, or insomnia)
- Any condition managed with Soma (Carisoprodol)

Patients receiving these treatments from another physician can be seen as new patients with the understanding that Dr. Jethro will not assume responsibility for prescribing these treatments at any time now or in the future. Dr. Jethro may also decline to prescribe any other medications with a high potential of dependency or addiction at her discretion.

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**Definitions and Clarifications**:

**Dependence** - **Physical dependence** caused by prolonged use of a drug refers to an altered physiologic state in which withdrawal symptoms develop when the drug is discontinued. **Psychologic dependence** refers to a state of intense need to continue taking a drug in the absence of physical dependence.

**Narcotics** – Medications in the opiate family used for pain. Examples: hydrocodone/Norco/Vicodin, Morphine, Oxycodone, Codeine, Tramadol, Dilaudid, Demerol, Fentanyl, Methadone, and many others.

**Benzodiazepines** – Diazepam (Valium), Alprazolam (Xanax), Lorazepam (Ativan), Temazepam (Restoril), Clonazepam (Klonopin). There are many alternative therapies for anxiety and insomnia.

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**Attestation:**

By signing below, I attest that I have read and understood all the above information. I understand that not all medications in each class have been listed and that these limitations extend to all medications in each class mentioned above whether or not they were listed.

Please sign and date:

Signature: _____ Date: _____

Name: _____ DOB: _____

Updated 1/25/26

# Financial Policy

To provide transparent and fair financial practices. Please read the following carefully:

- All **copays are due at the time of service**, prior to being seen by the provider. This is a legal requirement based on the agreement we have made with your insurance. We cannot waive or reduce copays as these are set by your insurance.
- Patients are responsible for **any deductibles, coinsurance, or non-covered services** as determined by their insurance carrier.
- We strongly encourage patients to be familiar with their insurance benefits.
- Any Adult bringing a patient under the age of 18 is the party responsible for payment.
- Patients must **bring their current insurance card to every appointment**.
- If insurance information is not provided or is found to be inactive, the visit will be considered **self-pay**. This includes Medicaid pending which will be billed as cash pay.
- We will file insurance claims for you but NOT third-party claims such and auto insurance or accident insurance.
- Patients without insurance, or those who prefer not to use insurance, must **pay in full at the time of the visit**.
- You may ask for an estimate of service costs before receiving any service.
- Cash, checks, VISA, discover, MasterCard, (not American Express).
- If you are unable to pay today, we ask that you speak with someone in the office so that we may authorize arrangements with your treating physician.

Thank you for reading and understanding. Please sign and date, indicating that you have read the above, understand, and are in agreement with the terms above.

_____ _____

Signature of patient Date

_____ _____

Signature of Legal Guardian Date

Updated 1/25/26

# Late Cancellation, Late Arrival, and No-Show Policy

**Late Arrival**

- If a patient is **more than 15 minutes late**, they are **not guaranteed their original appointment time**.
- We will do our best to accommodate late arrivals the same day **if possible**, but this may require waiting or rescheduling.

**Cancellations and No-Shows**

- We request that cancellations be made **at least 24 hours in advance**.
- After **three (3) no-show appointments within a 12-month period**, a **$25 fee** will be charged **for each additional no-show**, and dismissal from the clinic may be considered.
- No-show fees are the patient's responsibility and **will not be billed to insurance**.

Please Sign to indicate your acknowledgement and agreement to the above.

_____ _____

Signature of patient Date

_____ _____

Signature of Legal Guardian Date

Updated 1/25/26

# HIPAA Acknowledgment

Jethro Family Medicine is committed to safeguarding your protected health information (PHI). Please review the **General Notice of Privacy Practices** below.

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**General HIPAA Notice of Privacy Practices**

This notice describes how your medical information may be used and disclosed, and how you can access this information. Please review it carefully.

**How We May Use and Disclose Your Health Information**

Jethro Family Medicine may use or disclose your PHI for the following purposes:

- **Treatment:** To provide, coordinate, or manage your medical care.
- **Payment:** To obtain reimbursement from your insurance company or other payers.
- **Healthcare Operations:** For quality assessments, training, licensing, and administrative purposes.

We may also disclose PHI without your written authorization when required by law, such as:

- Public health reporting
- Abuse, neglect, or domestic violence reporting
- Health oversight activities
- Legal proceedings or law enforcement requests
- To avert a serious threat to health or safety

**Your Rights Regarding Your Health Information**

You have the right to:

- **Access** your medical record and request copies.
- **Request amendments** to your health information.
- **Request restrictions** on certain uses or disclosures.
- **Request confidential communications** in a specific manner.
- **Obtain a list of disclosures** made outside treatment, payment, and operations.

- **File a complaint** if you believe your privacy rights have been violated.

**Your Responsibilities**

- Notify us of any changes to your contact or insurance information.
- Communicate clearly if you have privacy requests or restrictions.

If you have questions or would like a full copy of our detailed Notice of Privacy Practices, please request one at the front desk.

**Patient/Guardian Initials (HIPAA Notice Reviewed): _____**

---** We are committed to protecting the privacy and security of your health information. This notice acknowledges that:

- You have been offered or provided access to the clinic's **HIPAA Notice of Privacy Practices**.
- You understand your rights regarding your health information, including how it may be used and disclosed.

**Patient/Guardian Initials: _____**

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**5. Consent to Treat**

By receiving care at, you consent to the following:

- Routine medical evaluation and treatment deemed appropriate by the provider.
- Diagnostic procedures such as physical exams, laboratory testing, and imaging when clinically indicated.
- Communication regarding your care, treatment plan, and results.

You understand that:

- You have the right to ask questions about any treatment.
- You may decline any treatment to the extent allowed by law.
- This consent remains in effect until revoked in writing.

**Patient/Guardian Initials: _____**

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**6. Authorization to Release Medical Information to Designated Individuals**

You may authorize Jethro Family Medicine to disclose your protected health information (PHI) to specific individuals such as family members, caregivers, or friends. This authorization allows us to discuss your medical care, appointments, billing information, or other health-related matters with the persons listed below.

**Designated Individual(s)**

**Name:** _____
**Relationship:** _____
**Phone:** _____

**Name:** _____
**Relationship:** _____
**Phone:** _____

**Scope of Information to Be Disclosed (Check all that apply):**

- [] All information medical and financial [] only medical [] only financial

This authorization:

- Remains valid until revoked in writing.
- Does not permit the designees to make medical decisions on your behalf.

**Patient/Guardian Initials:** _____

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**7. Emergency Contact Information**

Please provide the contact information for someone we may reach in case of emergency.

**Name:** _____
**Relationship:** _____
**Phone (Primary):** _____
**Phone (Secondary):** _____

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**Demographic Information**

Please complete the following information for administrative and billing purposes.

Name: Last: _____ First: _____ MI: _____

DOB: _____ SS#: _____

Address: _____ City: _____State: ___

Zip code: _____ Phone number: _____

Marital Status: _____

Employer: _____ Phone: _____
Email: _____

**Preferred Method of Contact:** _____

**Preferred Pharmacy:** _____
**Pharmacy Location/Phone:** _____

Employer: _____ Phone: _____

Employer Address: _____

**Responsible Party/Holder of insurance (write self if self):**

Relationship: _____ DOB: _____ SS#_____

Name: Last: _____ First: _____ MI: _____

Address: _____ City: _____State: ___

Zip code: _____ Phone number: _____

Marital Status: _____

Employer: _____ Phone: _____

# Medical History Intake Form

Please complete the following information to help us provide the best care possible.

**Past Medical History (Check all that apply):**

[ ] High blood pressure [ ] Diabetes Type I/Type II [ ] High Cholesterol [ ] Low Thyroid

[ ] Cancer [] Low bone density [ ] kidney disease [ ] Kidney stones [ ] Arthritis

[ ] Disability _____ [ ] Asthma [ ] COPD [ ] Heart Failure

[] PCOS [] Unwanted hair [ ] Seasonal/Food allergies [ ] Depression [ ] Anxiety

[] Insomnia [ ]Stroke [ ]TIA [ ] Sickle cell

Other: _____

**Surgical History Include date and Doctor if able.**

_____

_____

**Current Medications, please include dosage and frequency if able.**

_____

_____

**Allergies (medications, foods, materials):**

_____

_____

**Family History:**

- **Heart disease:** _____
- **Diabetes:** _____
- **Cancer (colon, breast, ovarian, etc)** _____
- **Other significant conditions:** _____

**Social History:**

**Tobacco Use:** Yes [ ] How much? _____ Last use? _____

Considering Quitting? _____

Updated 1/25/26

**Alcohol Use:** Yes [ ] How much? _____ Last use? _____

Considering Quitting? _____

**Recreational Drug Use:**

Yes [ ] What substance and how much? _____

Last use? _____

Considering Quitting? _____

**Occupation:** _____

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