# River City Endocrine Enrollment Forms

*Please review the included forms to become a patient of Dr. Dinh at River City Endocrine PLLC. If you have questions about these forms or registration, please email register@rivercityendocrine.*

**Includes:**

# Patient Agreement Form

*River City Endocrine PLLC*

This is a patient agreement between RIVER CITY ENDOCRINE PLLC, a Tennessee professional medical corporation, its physician Kathryn Dinh M.D. ("Physician") and you, the patient ("Patient," Name of patient) _____.

## Background

The Physician, who specializes in Endocrinology, Diabetes, and Metabolism, delivers care on behalf of River City Endocrine PLLC at 5104 Hixson Pike Hixson, TN 37343. In exchange for certain fees paid by you, River City Endocrine PLLC, through its Physician, agrees to provide Patient with the Services described in this Agreement on the terms and conditions set forth in this agreement.

## Definitions

1. Services: As used in this Agreement, the term Services includes Physician-delivered medical care rendered at the scheduled consultation or follow up visit, which can be in person or virtual via video or audio. Additional Physician access, which includes text messaging and email for medical care, has additional charges. These are offered by River City Endocrine PLLC as a part of its membership program.
2. Terms: If you are enrolled in membership, this agreement shall commence on the enrollment date of the membership and shall continue for a period of one month, automatically renewed per month. If you opt for Fee-for-Service visits, this agreement commences at the time of your New Patient Consultation.
3. Termination:
    a. Membership: Either party can cancel this agreement at any time by giving 30 days' written notice to the other of intent to terminate.
    b. Fee-for Service: If a patient opts to be seen in the "fee-for-service' Model, he or she will be Patient of River City Endocrine until a written notice of a patient's desire to terminate the relationship is received, a written notice of dismissal is delivered by River City Endocrine, OR at the time a patient has not attended a scheduled visit with Physician for a period of 2 years.
    c. Early Termination: If you cancel this agreement before its term ends, no refund of membership or consultation fee will be given, but no further charges will be made unless outstanding payments are due.
4. Payments and Refunds: Amounts and Methods
    a. In exchange for services, defined above, you agree to the payment for "fee for service" care or the monthly membership fee in the amount which appears in Appendix B.
    b. The 'Fee for Service' visit fee is due at the start of every visit. The membership fee is due once per month, on a date set by River City Endocrine PLLC, usually in consultation with the Patient.
    c. The parties agree that the required method of payment shall be by automatic payment through a debit or credit card or automatic bank draft.
5. Non-Participation in Insurance: Patient acknowledges that neither River City Endocrine PLLC nor the Physician participate in any health insurance including Medicare/Medicaid or HMO

plans or panels. Neither of the above make any representations whatsoever that any fees paid under this Agreement are covered by your health insurance or other third-party payment plans applicable to the patient. The Patient shall retain full and complete responsibility for any such determination.

   a. Medicare: The Patient understands that the Practice and staff have opted out of Medicare. As a result, **both the Patient and the Practice shall be prohibited by law from seeking reimbursement from Medicare for any Services provided under this Agreement**. Accordingly, the Patient agrees not to submit bills or seek reimbursement from Medicare for any such services. Furthermore, if the patient is eligible or becomes eligible for Medicare during the term of this Agreement, the Patient agrees to immediately inform the Practice and sign the Medicare private contract as provided and required by law.

6. Insurance or Other Medical Coverage: Patient acknowledges and understands that this Agreement is not an insurance plan, and not a substitute for health insurance or other health plan coverage (such as membership in an HMO). This agreement does not fulfill the requirements of any federal health coverage mandate. It will not cover hospital services, emergency room treatment, or any services not directly provided by River City Endocrine PLLC or its Physician. Patient acknowledges that River City Endocrine PLLC has advised that patients obtain or keep in full force such health insurance policy(ies) or plans that will cover Patient for general healthcare costs. Patient acknowledges that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health coverage that Patient may carry.
7. Communication: The Practice endeavors to provide Patients who enroll in membership with convenience of a wide variety of electronic communication options. Although Physician is careful to comply with patient confidentiality requirements and make every attempt to protect Your privacy, communications by email, facsimile, video chat, cell phone, texting, and other electronic means, can never be absolutely guaranteed secure or confidential methods of communications. By placing Your initials at the end of this agreement, You acknowledge that above and indicate that You understand and agree that by initiating or participating in the above means of communication, you expressly waive any guarantee of absolute confidentiality with respect to their use. You further understand that participation in the above means of communication is not a condition of membership in this Practice; that you are not required to initial this clause; and that you have the option to decline any particular means of communication.
8. Email and Text Usage: By providing an email address on the attached Appendix A, the Patient authorizes the Practice and its staff to communicate with him/her by email regarding the Patient's 'protected health information' (PHI). By providing a cell phone number in Appendix A and checking the "YES" box on the corresponding consent question, the Patient consents to text message communication containing PHI through the number provided. The patient further understands and acknowledges that:
   a. Email and text message are not necessarily secure methods of sending or receiving PHI, and there is always a possibility that a third party may gain access;
   b. Email and text messaging are not appropriate means of communication in an emergency, for dealing with time-sensitive issues, or for disclosing sensitive information. Therefore, in an emergency or a situation that could reasonably be

expected to develop into an emergency, the Patient agrees to call 911 or go to the nearest emergency care facility and follow the directions of personnel.

9. Technical Failure: Neither the Practice nor its staff will be liable for any loss, injury, or expense arising from a delay in responding to the Patient when that delay is caused by technical failure. Examples of technical failures: (i) failures caused by an internet or cell phone service issue; (ii) power outages; (iii) failure of electronic messaging software, or email; (iv) failure of the Practice's computers or computer network, or faulty telephone or cable data transmission; (v) any interception of email communications by a third party which is unauthorized by the Practice (vi) Patient's failure to comply with the guidelines for use of email or text messaging, as described in this Agreement.
10. Physician Absence: From time to time, due to such things as vacations, illness, labor and delivery, maternity leave, or personal emergency, the physician may be temporarily unavailable. When the date/s of such absence are known in advance, the Practice shall give notice to Patients so that they may schedule non-urgent care accordingly. During unexpected absences, Patients with scheduled appointments shall be notified as soon as practicable, and appointments shall be rescheduled at the Patient's convenience. If during Physician's absence, the Patient experiences an acute medical issue requiring immediate attention, the Patient should proceed to an urgent care or other suitable facility for care. Charges from urgent Care or any other outside provider are not covered under this Agreement and are the Patient's responsibility. The patient may, however, submit such charges to their health plan for reimbursement consideration or require that the outside provider do the same. The patient is responsible for understanding the coverage rules of their health plan and We cannot guarantee reimbursement.
11. Dispute Resolution: Each party agrees not to make any inaccurate or untrue and disparaging statements, oral, written, or electronic, about the other. We strive to deliver only the best of personalized patient care to every Patient, but occasionally misunderstandings arise. We welcome sincere and open dialogue with Patients, especially if Physician fails to meet expectations, and we are committed to resolving all Patient concerns. In the even that a Patient is dissatisfied with, or has concerns about, any staff member, service, treatment, or experience arising from their care in this Practice, the Patient and the Practice agree to refrain from making, posting, or causing to be posted on the internet or any social media, any untrue, unconfirmed, inaccurate, disparaging comments about the other. Rather, the Parties agree to engage in the following process:
    a. Patient shall first discuss any complaints, concerns, or issues with their physician;
    b. The physician shall respond to each of the Patient's issues or complaints
    c. If, after such response, Patient remains dissatisfied, the Parties shall enter into discussion and attempt to reach a mutually acceptable solution.
12. Monthly Fee and Service Offering Adjustments: In the event that the Practice finds it necessary to increase or adjust Membership or Fee-for-Service fees (Listed in Appendix B) before the termination of the Agreement, the Practice shall give 30 days' written notice of any adjustment. If Patient does not consent to the modification, Patient shall terminate the Agreement in writing prior to the next scheduled monthly payment (Membership) or scheduled visit (Fee-for-Service model).
13. Change of Law: If there is a change in any relevant law, regulation or rule which affects the terms of this Agreement, the parties agree to amend it only to the extent that it shall comply with the law.

14. Severability: If any part of this Agreement is considered legally invalid or unenforceable by a court of competent jurisdiction, that part shall be amended to the extent necessary to be enforceable, and the remainder of the Agreement will stay in force as originally written.
15. Amendment: Except as provided within, no amendment of this Agreement shall be binding on a party unless it is in writing and agreed to by all the parties.
16. Agreement: Neither this Agreement nor any rights arising under it may be assigned or transferred without the agreement of the parties.
17. Legal Significance: The Patient acknowledges that this Agreement is a legal document that gives the parties certain rights and responsibilities. The Patient agrees that they are suffering no medical emergency and has had reasonable time to seek legal advice regarding the Agreement and have either chosen not to do so or have done so and is satisfied with the terms and conditions of the Agreement.
18. Miscellaneous: This Agreement is to be construed without regard to any rules requiring that it be construed against the drafting party. The captions in this Agreement are only for the sake of convenience and have no legal meaning.
19. Entire Agreement: This agreement contains the entire Agreement between the parties and replaces any earlier understandings and agreements, whether written or oral.
20. No Waiver: Either party may choose to delay or not enforce a right or duty under this Agreement. Doing so shall not constitute a waiver of the duty or responsibility and the party shall retain the absolute right to enforce such rights or duties at any time in the future.
21. Jurisdiction: This Agreement shall be governed and construed under the laws of the state of Tennessee. All disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice.
22. Notice: Written Notice, when required, may be achieved either through electronic means at the email address provided by the party to be noticed or through first-class US Mail. All other required notice must be delivered by first-class US mail to the Practice at: 5104 Hixson Pike, Hixson, TN 3734 and to the Patient, at their address provided in Appendix A

The Parties agree that throughout this agreement and its attachments, checking the appropriate box next to their name will constitute an electronic signature and shall be valid to the same extent as a handwritten signature.

For: River City Endocrine PLLC

_____ _____

By Kathryn Dinh, MD Date

Patient:

_____ _____

Printed Name Date

## APPENDIX A

## PATIENT ENROLLMENT FORM

**CHECK YES WHERE INDICATED *ONLY* IF YOU AGREE TO TEXT MESSAGE COMMUNICATION. PROVIDE EMAIL ADDRESS *ONLY* IF YOU AGREE TO EMAIL COMMUNICATION.**

THE FEES AS SET OUT IN THE ATTACHED APPENDIX B, SHALL APPLY TO THE FOLLOWING PATIENT(S), WHO BY SIGNING BELOW ( OR AS LEGAL REPRESENTATIVE), CERTIFY THAT THEY HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THIS AGREEMENT:

**Patient**

Print Patient Name_____ Date of Birth_____

Street Address _____

City, State, Zip _____

Cell Phone_____ Alternate Number _____

Email_____

I Agree to Text Communication: (check one below)

- □ Yes
- □ No

Printed Name: _____ Relationship to Patient: _____

**Emergency Contact**

Name_____ Relationship:_____

Cell Phone_____ Alternate Number _____

I agree to sharing my private health information with this person as necessary:

- □ Yes
- □ No

Printed Name: _____

Signature: _____ Date: _____

## APPENDIX B

## FEE ITEMIZATION, PAYMENT POLICY, AND CREDIT CARD AUTHORIZATION FORM

**New Patient Consultation**

60 min New Patient Consultation* $ 400

**Includes CGM/Pump download if necessary and one 30 min follow-up phone call*

**Monthly Membership Fees**

Includes all Services** after New Patient Consultation $ 95

****Includes unlimited visits, as are medically necessary by Dr. Dinh, access to text/email with Dr. Dinh, CGM/Pump downloads, CGM training, phone calls, Prior Authorization Requests, and Forms/Letters as needed.***

**"Fee for Service" or Non-Membership Follow-Up Fees**

| | |
|---|---|
| 30 Follow-Up Visit | $ 300 |
| 60 min Follow-up Visit | $ 400 |
| Prior Authorization Request | $ 25 per each |
| Additional phone conversation with Physician | $ 300/hr, charged per 10 min |
| CGM and pump download | $ 50 per event |
| CGM Placement and Training | $ 100 per event |
| Any additional forms or letters | $25 each (excluding work excuse) |

---

**Total Due on Signing** **$ _____**

## RIVER CITY ENDOCRINE PAYMENT POLICY

River City Endocrine PLLC is an **out-of-network** provider. This means full payment is due from the patient at the time of service and we *do not bill* your insurance company. You will be financially responsible for services provided by out-of-network in excess of your applicable copayment, deductible, or coinsurance and that you may be responsible for costs in excess of those allowed by your health benefits plan. You are encouraged to obtain as much reimbursement for our services from your insurance company, except Medicare, but it is your responsibility to submit the paperwork. You may want to know what your insurance company considers 'ordinary and reasonable fees;' and we can provide the CPT codes. Of note, this is not true for patients with Medicare.

When lab-work is ordered, you have a choice of using our negotiated cash fee, which you will pay to River City Endocrine PLLC, or you use your insurance at the respective lab organization. If you choose to be billed by the lab organization, usually (but no guarantee) our lab orders will be reimbursed at your in-network rates as long as you go to those in-network lab organizations. Any radiology we order is billed by the respective radiology organization to you or your insurance. Usually (but no guarantee) our radiology orders will be reimbursed at your in-network rates as long as you go to those in-network lab organizations. You are responsible for obtaining this information regarding the network participation status of laboratories and radiology facilities, and you are free to use whatever facility you choose.

Initial: _____

## AUTOMATIC CREDIT/DEBIT CARD BILLING AUTHORIZATION

To enjoy the convenience of automated billing, simply complete the Credit/Debit Card Information section below and sign the form. All requested information is required. If you are a member of River City Endocrine, upon approval you will have the option to select a date for your monthly auto-deduction. Payments are made directly through our secure link accessed through your electronic statement sent to your email. Your statement will include monthly fees and incidental charges which you will receive prior to any payments or deductions. If you are being seen in the "Fee-for-Service" model, your payment for visits or additional services will be due at the time of service and can be paid through a credit or debit card kept on file.

**Customer Name**:_____

**PAYMENT INFORMATION**

I authorize River City Endocrine PLLC, to automatically bill the card listed below as specified:

- Amount: $ 95 for monthly subscription and Incidental Charges;
- Amount required for "Fee for Service" visits per Appendix C and Incidental Charges;

**Frequency for Membership:**

Monthly Start billing on: ____/____/____

End billing when: Customer provides written cancellation

**CREDIT/DEBIT CARD INFORMATION:**

Credit card type: **[ ]** Visa, **[ ]** MasterCard, **[ ]** American Express, **[ ]** Discover

_____ _____/_____ _____

Credit card number: Expires: CVC (Security Code)

_____

Cardholder's name: As shown on credit card

Customer's signature: Date:

_____

AUTHORIZATION BY INDIVIDUAL TO SIGN/ACT ON BEHALF OF THE PATIENT

_____

DATE

_____

SIGNATURE

## APPENDIX C

## MEDICARE OPT-OUT AGREEMENT

This agreement ("Agreement") is entered into by and between River City Endocrine PLLC ("Provider"), whose principal medical office is located at: 5104 Hixson Pike, Hixson, TN 37343, and _____(Patient's Name), a beneficiary enrolled in Medicare Part B ("Beneficiary"), who resides at

_____

_____(Patient's address).

**Introduction**

The Balanced Budget Act of 1997 allows Providers to "opt out" of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, Providers are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the Provider not opted out of Medicare). In essence, the Provider must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years. This Agreement between Beneficiary and Provider is intended to be the contract Provider are required to have with Medicare beneficiaries when Providers opt-out of Medicare. This Agreement is limited to the financial agreement between Provider and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

**Provider Responsibilities**

(1) Provider agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.

(2) Provider agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

(3) Provider agrees not to execute this contract at a time when the beneficiary is facing an emergency or urgent healthcare situation.

(4) Provider agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Provider also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Provider agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

**Beneficiary Responsibilities**

(1) Beneficiary agrees to pay for all items or services furnished by Provider and understands that no reimbursement will be provided under the Medicare program for such items or services.

(2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Provider for such items or services.

(3) Beneficiary agrees not to submit a claim to Medicare and not to ask Provider to submit a claim to Medicare.

(4) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Provider that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

(5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from Provider and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other Providers or practitioners who have not opted out of Medicare.

(6) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make Payments for such items and services not paid for by Medicare.

(7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

**Medicare Exclusion Status of Provider**

Beneficiary understands that Provider has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

**Duration of the Contract**

This contract becomes effective on _____, 20____. Either party may terminate treatment with a 30-day notice to the other party. Notwithstanding this right to terminate treatment, both Provider and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

By _____
River City Endocrine PLLC,

Patient's Signature: _____ Date: _____

River City Endocrine PLLC

5104 Hixson Pike, Hixson, TN 37343

## HIPAA Privacy Policy

Please sign/initial below indicating you have received this notification of your Federal Health Care Privacy Rights. This notice describes how protected health information may be used and disclosed and how you can get access to this information. We are required by federal law to give you this notice.

Under the health, insurance, portability and accessibility act, (HIPAA), River City Endocrine PLLC is required by law to maintain the privacy of protected health information As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. However, River City Endocrine PLLC can use and disclose your protected health information for treatment, payment, and healthcare operations as well as any other use required by law. River City Endocrine PLLC has a legal duty to notify you of a breach of any unsecured protected health information as defined by applicable regulations and to abide by the terms of this notice.

1. Treatment--we may use and disclose your health information to a physician or other healthcare provider providing treatment to you. This may include providing information on your dates of service and medical condition being treated to your health plan and pharmacy for approval of treatments prescribed, labs or imaging requested, or procedures ordered.
2. Payment – we may use and disclose health information in connection with all activities related to billing and obtaining payment for services we provide you.
3. Healthcare operations – we may use and disclose health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, education, and business management.

Most uses and disclosures that do not fall under treatment, payment, health operations will require your written authorization. We will not use your health information for marketing communications without your written consent.

Other disclosures required my law include:

- In the event of your incapacity, or an emergency, we will discuss health information with a family member, or other person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your immediate healthcare.
- We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other peoples health and safety.
- We may disclose the health information of armed forces personnel to military authorities under certain circumstances. We may disclose health information to authorize federal

officials, required for lawful intelligence, counter intelligence, and other national security activities.
- We may disclose the health information as required for public health; for example, we are required to report certain communicable diseases to the state public health department.

We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

**You have the right to revoke your authorization in writing to our practice at any time**, except to the extent that River City Endocrine PLLC or Physician has taken an action in reliance or the use or disclosure indicated in the authorization.

You have the right to:

1. Receive confidential communications regarding your protected health information
2. Inspect a copy of your protected health information
3. Amend your protected health information. River City Endocrine PLLC may deny this request, but will tell you in writing within 60 days.
4. Receive an account of disclosures of your protected health information aside from those required for treatment, payment, and healthcare operations.
5. Receive a paper copy of this notice of privacy practices.

You have the right to choose someone to act for you through assigning someone as medical power of attorney or as a legal guardian. That person can, therefore, exercise rights and make choices about your health information. River City Endocrine PLLC will need to have copies of legal documents to confirm a person aside from the patient has the authority to act for you before we take any actions.

If you have any complaints regarding the way your protected health information was handled or have concerns that your privacy rights may have been violated, you may submit a complaint in writing to our office. Our Privacy Office is Kathryn Dinh, MD. You may also send a written complaint to the US Department of Health And Human Services, Office of Civil Rights. You will not be retaliated against in any manner for a complaint.

River City Endocrine PLLC reserves the right to revise or amend our notice of privacy practices without additional notice to you. Any revision or amendment will be effective for all of your records this practice has created or maintained in the past or in the future. River City Endocrine PLLC will post a copy of this Notice as amended in a prominent location in the office and on the website.

This notice is effective 12/1/2023, last updated 11/9/2023. For further information about River City Endocrine PLLC privacy policy, please contact our office at the following address or phone number:

Initial: _____

River City Endocrine PLLC

5104 Hixson Pike, Hixson, TN 37343

**Technology Notice (in accordance with TCPA)**

In accordance with the TCPA, this form details technology used for communication.

River City Endocrine PLLC and Dr. Kathryn Dinh provide care outside of regular face to face office visits, through phone calls, telemedicine/telehealth platforms, text message and email. For logistics, we can also be reached by mobile device text messages and emails for both general inquiries and for providing healthcare. You acknowledge traditional email and related online platforms (Gmail, Yahoo, google, etc) and text (iMessage, voice over internet technology, Google Voice, mobile sms, etc), are **NOT** HIPAA secure and are not for emergencies. By signing, you acknowledge these methods are NOT secure. You are also not obligated at all to use them, but we will then be limited to communication by telephone calls or in the office face to face.

Text and email will be saved into the patient record. It may take up to 72 hours to respond to questions and requests. **Text and email may not be used for emergency health concerns. Call 911 for all or any emergencies.**

You also consent to all River City Endocrine to electronically access your medication, medical history, any relevant laboratory or imaging results & immunization history to ensure accurate medication treatment and coordination of care.

Federal law has placed restrictions on us contacting you on your mobile phone. The Telephone Consumer Protection Act requires businesses like us practicing direct care to get explicit consent to contact you on a mobile phone.

By acknowledging and signing below, you are granting permission for River City Endocrine PLLC to contact you on the mobile phone number(s) listed below. You can choose to call and text or just call (no text). Contact can be a text message appointment reminder or ‘robot-call’ appointment reminder. You can opt-out at any time. By signing below, you represent you are the wireless subscriber or customary user and you have authority to provide consent. Message and data rates may apply by your mobile provider.

Cell phone number: _____ ☐ Phone ☐ Text

Name: _____ Date: ___/____/20___

Initial : _____