## Financial Policies and Agreement

*The following are the financial policies of Rachel Lee Patient Advocacy Consulting, LLC.*

*Referred to below as RLPAC.*

- Payment is due at the time of service for all regular consults and initial consults.
    - Initial Consult: $250.00, 1.5-2.0 hours. Includes follow up paperwork, initial research and initial patient care planning.
    - Regular Consult: $50.00/half hour, $95.00/hr + $25 for each additional 15min. Appointments will not last longer than 1.5 hours unless the client has already scheduled back to back appointments.
- Payment will be billed within five business days for in-person advocacy visits to physicians, hospitals and/or other emergency advocacy support not previously arranged.
- Clients who fail to cancel an appointment **24 hours prior** to the time of the appointment as scheduled will be obligated for the full amount of the service. *(Unless a patient has signed up for the emergency advocacy program, see below).*
    - It is the client's responsibility to clearly communicate what type of appointment they are scheduling. Email records and advocate notes will be kept on file.
- All fees are non negotiable. Billing will not be adjusted if the client declines specific services.
- Payment for the emergency advocacy program is automatically charged on the 1st or 14$^{th}$ of each month.
    - Is required for an advocate to be present with me at the ER.
- I understand that patient advocacy is not covered by medical insurance, and I agree to take on the expenses of any services which I engage.
- I understand that I will be fully informed of the costs for my services prior to engaging them by Rachel Lee Patient Advocacy Consulting, LLC. and agreed to pay promptly and in full for the services I receive.
- I agree to promptly notify RLPAC if I become unable to pay for my services in the agreed upon manner. *(These situations are handled on a case by case basis and RLPAC will do its utmost to ensure that no established client is left without emergency support services due to an inability to pay).*
- I give my consent for RLPAC to keep a singular record of my payment information. I acknowledge here that I personally provided this information on my intake form.
- I agree to keep my payment information up to date.

- For additional services not billed at the time of service, I understand that I will receive notice of my bill in writing, and am expected it to remit payment within 10 business days of its receipt.
- For billing purposes and to be eligible for a payment plan, the definition of an established client is one who has completed an initial consult and all follow up paperwork and document submission. Furthermore, an established client is a patient who has attended at least one consult, once a month for a period of three months, - OR - at minimum three follow-up consults within one month of the initial consult.
    - I, the client/patient, have read and agreed to the definition provided above. I understand that I will not be offered a payment plan in the event of a financial emergency or other extant circumstance if I have not met the above criteria.
    - Client initial _____

I _____ (Full Name) hereby acknowledge that I have read, understand, and agree to the financial policies and expectations of payment for engaging the services of Rachel Lee Patient Advocacy Consulting, LLC.

Signature of client/patient or legal guardian _____

Date of Signature _____

## Informed Consent

*Please read each of the following statements and provide your initials beside each statement. Your signature will be required below.*

**Printed Full Name _____ Date_____**

- I understand that I will be offered and may agree to receive the following health consulting services for my condition(s) from Rachel Lee Patient Advocacy Consulting including but not limited to the processes of medical discovery, diagnosis, treatment, follow up, coordinating and preparation for appointments, assistance with insurance companies and appeals, guidance to medical professionals, educational resources, research services into conditions and the operations of institutions which care for them, and in-person advocacy for me, at my request, with my physicians and or institution of care.
- I understand that I choose to receive these services and that I can refuse any of these services at any time with the understanding that doing so may severely limit what my advocate is able to do for me.
- I understand that I am an active participant in decisions affecting my medical and or support services.
- I understand that in the course of advocacy and consulting, my advocate may need to address specific concerns about myself or my plan of care which I may find uncomfortable or triggering. I understand that it is my responsibility to be transparent about any mental, emotional or physical triggers that I am aware of with my advocate and that he/she is not responsible for any triggers that I have not disclosed. I understand that even though I may prefer not to approach certain topics, diagnoses or treatments, it may be necessary for my advocate to mention them within the context of a specific problem or communication. I understand that this is done with my own well being in mind.
- I understand that mental health issues are a significant symptom in many chronic illnesses and their co-conditions, and while I may have specific desires about the course of mental health treatment, I cannot require my advocate to completely refrain from discussing anxiety, depression, obsessive compulsive behaviors, suicide and other mental health concerns that may be relevant to me. I understand that I can discuss this further with my advocate at any time, and voice my concerns or fears on this subject openly.
- I understand that my advocate is not a mental health professional and is not responsible for my mental and emotional well being beyond the scope of what is naturally included in the patient-advocate relationship. This relationship includes but is not limited to disclosure of mental and emotional triggers, diagnoses, and treatments I am undergoing, and natural conversation about how I feel about a physician, appointment, diagnosis,

procedure or treatment, and possible communication with family members or friends involved in my care.

- I understand that I should not ask my advocate to become involved in or counsel me about personal relationships except when it may directly impact my healthcare. I understand that my advocate must use his/her best personal discretion in these circumstances and may refuse to speak with another individual on my behalf, or counsel me about interpersonal issues with my family, friends, coworkers etc.
- I understand that Rachel Lee Patient Advocacy Consulting is not a physician or licensed medical professional clinic. Discussion about treatments, procedures, medications, and any other aspects of my medical care are strictly for the support and education of myself as a patient. I acknowledge that I am expected to consult with a qualified medical professional in an established health care setting before making any changes or additions to my health care routine.
- I understand that I may request notes and documentation of my appointments with RLPAC for my own records and to present to physicians or any other medical providers involved in my care. Furthermore, I acknowledge that obtaining copies of these notes and submitting them to any person outside of RLPAC is my personal responsibility.
- I have been informed that RLPAC is HIPAA compliant, that any information disclosed during the course of my engagement, medical or otherwise, is automatically protected and that it will not be released to any other parties or persons without my prior authorization.
- I understand that my advocate at RLPAC is legally required to report certain situations to appropriate authorities including, but not limited to: suspicions of abuse and/or neglect of a minor, suspicions of abuse and/or neglect of a disabled adult, suicidal and/or homicidal threats (pose a danger to self or others).
- I understand that I have the right to discontinue my services at any time. I agree that should I need to discontinue services I will inform RLPAC over the phone (not voicemail), or in writing. *No appointment is required.*
- I have been informed that RLPAC policy is to support me as my own best advocate. To that end, RLPAC does not establish medical power of attorney on my behalf.
- I understand that patient advocacy by its very nature is committed to supporting me as a unique individual and that my advocate will, in their capacity as my medical representative, support me by vocalizing my questions, desires or other needs regarding health care, to a physician or a member of health care system.
- I understand that my advocate uses his/her own discretion concerning what information, procedures, treatments and any other medical care I express a desire for, is unethical, or harmful to me in my condition. I understand that my advocate will not advocate for

treatment, procedures, or any medical plan of care that is unethical or harmful to me, and that he/she will not be penalized for that decision.

- I understand that my advocate will not lie on my behalf or conceal vital medical information from my physicians in an emergency. Furthermore, no advocate will participate in any scheme which may amount to manipulation or deceit of a medical care professional or institution from which I am receiving care, or hope to receive care. This includes but is not limited to private practice, hospitals, outpatient clinics and insurance companies.
- I understand that in order to perform her services as my patient advocate and consultant I will be asked to sign a HIPAA release form designating my patient advocate by name as my Designated Personal Representative, and that I must supply a copy of this consent to any medical practitioner or health care system which in which I anticipate requiring support. *(RLPAC will also keep a digital copy on hand in case of emergency and bring a copy to any in-person consulting meetings or appointments).*

I, the client/patient named here, acknowledge that I have read and understand the policies of RLPAC outlined above and hereby give my informed consent for patient advocacy and consulting.

Signature_____ Date:_____

**Optional:** I give permission for Rachel Lee Patient Advocacy Consulting to share relevant information about my journey as a part of its ongoing patient advocacy, community advocacy and system-change advocacy efforts. I understand that I will be kept anonymous in all of these exchanges. Should there be any part of my story which I do NOT want shared at the discretion of RLPAC, I will make that clear to my patient advocate.

Signature_____ Date:_____