

*****EFFECTIVE IMMEDIATELY!*****

Appointment No Show – 24 Hour Notice Policy

A patient will be considered a “no show” if he/she misses his/her scheduled appointment time or cancels with less than a 24 hour notice. When this occurs, *Rheumatology Associates of Central Florida* loses the opportunity to care for other patients who need to be seen. If a 24 hour notice is not received or a “no show” occurs, you will be charged a fee:

- \$50.00 for an ESTABLISHED patient
- \$100.00 for a NEW PATIENT appointment
- \$50.00 for an INFUSION, X-RAYS or DEXA SCAN appointment

This fee is not covered by insurance and is therefore the sole responsibility of the patient. Please be aware that confirmation calls are a *courtesy* and not the responsibility of the office.

I, (print name) _____, understand and acknowledge that *Rheumatology Associates of Central Florida* has a policy to charge me a \$50.00 or \$100.00 fee if I fail to come for my scheduled appointment. I agree:

- To pay this fee, when applicable
- That I understand I will be unable to reschedule until fee has been paid

Patient or Parent/Guardian Signature

Date

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FINANCIAL POLICY

Welcome and thank you for choosing Rheumatology Associates of Central Florida for your medical care!

We are committed to providing you with the highest quality care and achieving desired outcomes through a collaborative effort with you, our patient.

It is important that you understand our financial policy but equally important that you understand the terms of your medical coverage. Although our staff is very knowledgeable about the various insurance plans with which we participate, you are in the best position to understand the detailed terms of your specific plan. Typically, your insurance carrier provides you with specific benefit questions or concerns you may have regarding your coverage.

Our professional fees have been determined through careful consideration of reasonable and customary charges within our geographical area. We are always happy to discuss with you any questions you may have concerning a bill.

Insurance

Please remember that your insurance is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment for services from the insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Uninsured Patients

If you do not have medical insurance, we will extend cash pay rates to you. These rates are only if payment is made in full at the time of service.

General

- Please be prepared to pay the current visit as well as any past due balance on your account at the time of service unless payment arrangements have been made with the billing department **prior** to your visit.
- If the patient is a minor, the parent(s) or legal guardian(s) are responsible for payments. In cases where a written court document allows payment for medical costs it is the accompanying parents' responsibility to obtain reimbursement from the other party involved.
- Social Security Numbers are a necessary part of your financial information with our office. This information, as with any of your medical records, is protected with strict confidentiality. We are extending a line of credit by filing insurance for your charges and not collecting in full at the time of service, therefore we must have this information. If you do not wish to provide your social security number, we will require payment in full at the time of service.
- Balances that remain outstanding more than 60 days after the date of service (or payment by your insurance carrier) will result in a disruption of immunotherapy services and the cancellation of upcoming appointments. The balance may also be considered for referral to an outside collection agency.
- Accounts referred to an outside collection agency or attorney may be subject to a collection fee, which will be added to the original balance.
- Patients with unpaid delinquent accounts or accounts that have been sent to an outside collection agency will be expected to pay their account in full prior to being seen for a non-emergent visit.
- A \$35.00 fee will be assessed for any returned checks, plus any bank fees. We will require all future payments by cash, cashier's check, or debit/credit card.
- A \$100.00 fee will be applied to new patient accounts for no shows and cancellations with less than 24 hour notice.
- A \$50.00 fee will be applied to established patient accounts for no shows and cancellations with less than 24 hr notice.
- A \$50.00 fee will be applied to infusions, x-rays, and DEXA scans for no shows and cancellations with less than 24 hour notice.
- Our office is not party to your divorce decree. The financial responsibility for minors rests with the parent who signs the financial policy.

Form Completion and Fees

We understand that there may be times when you need a form completed by your physician (i.e. medical leave, disability forms). We are willing to assist you with these requests. These forms require research and time on the part of the staff and physicians. The volume of requests and complexity involved, make it difficult to complete them at the time of your visit. We ask that you allow 7-10 business days for completion of these requests. Based on the amount of information requested, fees will be discussed prior to completion.

Medical Records

A medical records release form must be filled out for the release of any medical records. Records released to the patient can be provided for a fee of \$1.00 per page for the first 25 pages and .25 cents for each page thereafter.

I HAVE READ AND AGREE TO ACCEPT THE FINANCIAL POLICY(S) AS WRITTEN:

Patient or Parent/Guardian Signature

Date

PRIVACY POLICY

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

At Rheumatology Associates of Central Florida, PA, we are required to keep your health information secure and confidential, by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue SW, Room 509F, Washington, DC 20201), online (www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Nancy Deler at (407) 859-4540 for more information. To make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgement

I have received a copy of Rheumatology Associates of Central Florida, PA, Notice of Privacy Practices.

Patient or Parent/Guardian Signature

Printed Name

Date

Health Information Portability and Accountability Act (HIPAA)

PLEASE PRINT CLEARLY

Patient Name: _____

Address: _____

Email Address: _____

Healthcare Surrogate/Emergency Contact: _____

Emergency Contact Phone Number: _____

Preferred Lab: _____ LabCorp _____ Quest

In general, the HIPAA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

Home telephone:

Ok to leave message with details _____
Leave message with call back number _____
Authorized person to speak with: _____

Cell phone:

Ok to leave message with details _____
Leave message with call back number _____

Written Communication:

Ok to mail to my home _____

Email:

Ok to send email with details _____

Work Telephone:

Ok to leave message with details _____
Leave message with call back number _____

I give Rheumatology Associates of Central Florida, PA, permission to use and disclose PHI necessary to carry out treatment or payment. By signing this form, I understand that the privacy practices of the office have been disclosed to me.

Patient or Parent/Guardian Signature

Printed Name

Date