
# HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

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## A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1.Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2.Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3.Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4.[Optional]: Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5.Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6.Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7.Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8.Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9.Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10.Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11.Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12.Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13.Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14.Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15.Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16.Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17.Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18.Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19.Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20.Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21.Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your e- mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22.Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use, or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you

with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add:* We will also post the current notice on our website.)

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

**OCRMail@hhs.gov**

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcompla...**.

You will not be penalized in any way for filing a complaint.

Patient/Guardian Signature: Date:

_____ _____


# Privacy and Billing Consent Form

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

**Consent Related to Privacy Notice:**

I _____ have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

**Consent for Care:**

I, _____ with my signature, authorize Rheumatology and Arthritis Care Center and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

**Consent for Release of Information and Assignment of Benefits:**

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

**Financial Policy:**

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all **co-payments, deductibles**, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations. If I have an insurance co-payment or deductible, I am expected to make payment when checking in for my appointment. **_____** ***(Patient Initials)***
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. RHEUM & ARTHR CENTER is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. For example, not all health plans include screenings as a benefit. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred. **_____** ***(Patient Initials)***

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

Patient/Responsible Party: _____ Date:_____

Rheumatology and Arthritis Care Center

# PATIENT CONSENT

I, _____ hereby states that by signing this Consent I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) text message sent by Phreesia or by Klara b) telephoning my designate phone number and leaving a message on my answering machine or with the individual answering the phone.

4. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

7. I understand that if l do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

Patient/Guardian Signature: Date:

_____ _____


# Patient Communication Consent Form

From time to time in caring for our patients it may become necessary to contact you. Often our patients are not available when we call and we would like to be able to leave detailed telephone messages when possible. There are also times where you may want us to communicate labs, medications, treatment plans, or billing information to a trusted family member or friend. To protect your privacy, we need your written permission to leave detailed messages on your answering machine, voicemail or with a trusted family member or friend.

☐ **I DO CONSENT**

I _____ consent for my healthcare provider to leave detailed message regarding my personal health information (PHI) using the following options: (Provide information below) **Please note this consent will remain in effect until you rescind in writing.**

Home Phone Number _____

My Cell Phone Number _____

My Work Phone Number _____

Name of Family or Friend and Phone Number _____

Please state relationship to patient _____

Name of Family or Friend and Phone Number _____

Please state relationship to patient _____

**I DO NOT CONSENT**

☐ For my provider to leave detailed telephone messages regarding my personal health information (PHI)

☐ For my provider to communicate messages regarding my personal health information (PHI) to family members.

**REVOCATION OF PRIOR CONSENT**

☐ I wish to rescind or stop any prior consent to leave detailed messages.

☐ I wish to rescind or stop any prior consent for my provider to communicate messages regarding my personal health information (PHI) to family members.

Patient and/or Patient's Representative Signature _____ Date _____

Rheumatology and Arthritis Care Center

# OFFICE POLICIES

In order to obtain the best medical care possible, we expect the highest level of service and care from ourselves. We will always work closely with your primary care physician in order to provide the best and most appropriate care for you. We also expect patients to take an active role in their care and work within the guidelines that the clinic operates.

## Appointments:

-We will always try to schedule your appointments promptly and at your convenience.

-If you cannot make an appointment, please give more than 24 hours' notice. We try to provide courteous and respectful care to our patients and expect the same in return.

-If you do not show for a scheduled appointment or cancel/reschedule your appointment 24 hours prior to your scheduled appointment, you will be charged a no show or late cancellation fee.

**The fee for no show, same day cancel, same day reschedule is $50.00.**

-Arrive 15 minutes before your scheduled appointment time in order to properly check in and prepare for your visit.

-All new patients seen by the Nurse Practioner and our Physician Assistant will also be seen by the doctor during their initial visit.

## Refills/Prescriptions given at the time of your visit:

-Please make sure to ask for refills before leaving the office.

-If a refill is needed prior to your next visit, contact our office directly via phone or text. We do not process refill requests that come from pharmacies or third parties.

## Laboratory Test Results, X-ray Results or any Medical Testing Results:

- With your written consent you have access to your medical records from our office through our patient portal to view results. Optional access to your records include HIPAA secure texting, faxing, USPS, and patient pick-up.

- A follow up appointment is required to discuss test results with interpretations and treatment plans with the physician.

## Financial Policy

Acceptance of our financial policy is mandatory in order to be seen in our clinic. This includes having a credit or debit card on file with our office to cover any outstanding account balances. We comply with all appropriate state, federal, and medical regulations regarding protection of your information and privacy.

By signing below you agree and consent to the above stated policy

Patient/Responsible Party: _____ Date:_____

Rheumatology and Arthritis Care Center

# INSURANCE AND BILLING POLICIES

**Below you will find a list of our office billing policies. These are <u>NON- NEGOTIABLE</u> policies and apply to every patient account.**

1. Let us know if your insurance has changed in any way, even if only your policy number. We need this information in order to properly write for your medications, labs and radiology tests. We also require the patient's social security number for this as well. Your record will not be seen or shared with any outside facility. Our records are completely private.
2. If you are a member of an HMO, please make sure your primary care physician provides us with a REFERRAL before your appointment.
    a. ***You will be responsible for obtaining all required referrals for your office visit(s). If you are seen in our office without a referral you are responsible for the total cost of your visit.***
3. <u>Co-payments</u> are expected at the time of check-in. We accept cash, card, and check. If you are unable to provide your co-payment at the time services are rendered, you will be asked to reschedule your appointment. _____ ***(Patient Initials)***
4. <u>High Deductible plans -</u> payment will be due at the time of service in the amount of $125.00. After insurance processes your claim, you may receive a refund if you paid in excess, or you may receive a bill if the $125.00 does not cover the full amount owed. _____ ***(Patient Initials)***
5. You must have a current copy of your insurance card at every visit to be seen by the physician.
6. Our office makes every attempt to obtain payment from your insurance company in a timely manner
7. Our office will contact you if there is ever any issue with our office receiving payment from your insurance company. If there are any problems receiving payment from your insurance company:
    a. You will have 30 days from the day of the denial to correct any issues with your insurance company that may be preventing our office from receiving payment.
    b. Our office will only bill your insurance company within a 90 day period after the date of the corresponding visit. After 90 days, if your insurance company has not paid your claim, payment is expected from you (the patient) in full. Our office will then provide you with the appropriate billing codes in order to bill your insurance company directly. _____ ***(Patient Initials)***
8. Billing Statements are sent out the first of every month (30 day cycle).
9. Within 90 days of your first billing statement you will have to complete one of the two options listed below.
    a. Pay your account balance in full
    b. Set up a payment plan _____ ***(Patient Initials)***
10. We require a form of payment on file, either credit or debit card, in case your account is over 90 days unpaid in which case you will be notified your card will be charged for any outstanding balance.
11. Failure to comply will result in your account being sent to a collection agency. Once your account is in collections you will be required to make payment directly to the collection agency.

By signing below you agree and consent to the above stated policy

Patient/Responsible Party: _____ Date:_____

Rheumatology and Arthritis Care Center

# FINANCIAL POLICY

Our clinic participates in many insurance health care plans. If you are unsure if this practice is in network with your specific health insurance carrier and your specific health insurance plan/policy, we encourage you to contact your respective health insurance company for clarification.

If you are covered by one of our accepted insurance plans, and can provide a valid insurance card or other evidence of coverage, we will bill your insurance for your rheumatology services. You are responsible for providing us with the most current copy of your insurance card at the time of service.

**If you are not covered** by one of our accepted plans, you must **pay in full at the time of service**. Please be aware that there could be additional charges at your office visit including injection charges if you have any additional procedures done during your visit. Many insurance plans do provide reimbursement for "out-of network" care. Please contact your insurance company to determine how to submit a claim form and the rules governing visits to out-of-network physicians. A complete list of costs associated with office visits can be obtained at the front desk

**MEDICAID / STATE INSURANCE**

We do not accept any State Medicaid plans. This is made clear to all patients on our website, and during new patient booking. If a patient denies having a primary or secondary insurance that is Medicaid and presents to the office with a Medicaid insurance, we reserve the right to turn you away and cancel your appointment. If a patient denies having Medicaid after an initial appointment and the billing department discovers Medicaid is active, we reserve the right to terminate you as a patient.

**INSURANCE COMPANY LAWS**

Pennsylvania State law requires insurance carriers to pay claims within 30 days of receipt. In situations when your insurance carrier pays its portion and leaves you accountable for the remaining payment portion, you will be accountable to submit this payment within 30 days from receipt of our billing statement. If your insurance carrier delays or withholds payment for 90 days or longer, both the insurance and patient portions will become your responsibility. You will be billed for the total account balance, and if not paid within 90 days, your account will be sent to a collection agency. Payment plans are available if needed. If you intend to set up a payment plan with our office Payment plans are available for a six month time period. After the expiration of the six month time period your account is expected to be paid in full. You must contact our office within 30 days following the receipt of the patient responsibility statement. We strongly suggest you monitor your personal account with us, contact our Billing Department at 484-206-4447 EXT 107. As your balance ages beyond 30 days, we recommend calling your insurance carrier and requesting a "claim status report".

**SELF-PAY (Uninsured) Fee Schedule**

Our office follows the fee schedule set by Medicare.

**New patient visit: $225.00** **Revisit: $125.00** **High Deductible visit: $125.00**

By signing below you understand, agree and consent to the above stated policy

Patient/Responsible Party: _____ Date:_____

Rheumatology and Arthritis Care Center

# CREDIT CARD ON FILE POLICY

Rheumatology and Arthritis Care Center will make a best effort to work with each patient and their insurance provider to reconcile any payment disputes. We strongly suggest you monitor your account carefully and we will ensure our best effort to make this as smooth a process as possible.

In order to ensure continuity of care with our practice, we require that you maintain credit card information on our secure database. We understand your concerns with providing us this confidential information but we assure you that this information will be kept confidential. You will be given 90 days from the date of your first billing statement to either pay your balance in full or set up a payment plan with our office. We will not charge your credit card during that 90 days' time frame as you will have multiple opportunities to pay off any account balances. If the bill remains unpaid, we will contact you to charge your card. Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged. If you have any questions about our policy, please do not hesitate to ask.

I hereby acknowledge receipt of the services, authorize Sucharitha Shanmugam MD and Rheumatology and Arthritis Care Center LLC to bill the credit card I have provided above to keep on file for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.

By signing below, I hereby acknowledge I have read all of the above in its entirety and agree to the house rules, financial policies, and insurance/billing policies of Sucharitha Shanmugam MD and Rheumatology and Arthritis Care Center.

_____ _____

Print Name Date

_____

Signature


# Rheumatology and Arthritis Care Center Patient Code of Conduct Agreement

At Rheumatology and Arthritis Care Center, we provide quality healthcare services to our patients. To ensure the well-being and comfort of all patients and staff, we have established this Patient Code of Conduct Agreement. We ask that you carefully read and adhere to these guidelines during your visits to our practice.

## Patient Responsibilities

1. **Civility policy:** We expect our staff to be civil and respectful of all patients, and we also expect our patients to treat their providers and ALL staff with civility, respect, courtesy and consideration. Failure to do so will result in discharge from the practice.
2. **Confidentiality:** Patients should respect the privacy and confidentiality of other patients and the information shared within the practice.
3. **Follow Medical Advice:** Patients should follow the medical advice and treatment plans prescribed by their healthcare provider.
4. **Payment Obligations:** Patients are responsible for any applicable fees, co-pays, or deductibles associated with their healthcare services and should make payment arrangements as needed.
5. **Medication Management:** Patients should inform their provider of all medications, supplements, and treatments they are currently using and follow prescribed medication regimens.
6. **Non-Discrimination:** Discrimination, harassment, or any form of offensive behavior or language towards staff or other patients based on race, gender, religion, nationality, disability, sexual orientation, or any other characteristic will not be tolerated.
7. **Safety:** Patients should adhere to safety guidelines and instructions provided within the practice, including proper use of medical equipment and adherence to infection control protocols.
8. **No Show/Cancellation Policy:** Patients who repeatedly miss appointments or cancel without adequate notice may be subject to our no-show/cancellation policy, which may include fees or limitations on future scheduling.
9. **Late Arrival:** We expect all patients to be on time for their appointments. We ask that all patients check-in 15 minutes before their New Patient appointments and 10 minutes before their established patient visits. If you arrive after your scheduled appointment start time, you may be asked to reschedule.
10. **Insurance**: Our patients may require Prior Authorizations for injections, infusions, medications and some insurance plans require referrals. It is patients' responsibility to inform Rheumatology and Arthritis Care Center if and when they have changes or additions to their insurance coverage so that we can update any existing Prior Authorizations and properly bill for services.

## Consequences of Violating the Code of Conduct

Violations of this code of conduct may result in various actions, including, but not limited to, verbal counseling, written warnings, discharge from the practice, or reporting of serious misconduct to appropriate authorities. By signing below, I acknowledge that I have read, understood, and agree to abide by the Rheumatology and Arthritis Care Center Patient Code of Conduct Agreement. I understand that failing to adhere to these guidelines may have consequences as outlined above.

Patient Full Name:_____ Date:_____

Patient Signature:_____