Policies Packet

Authorization to treat

I understand that I am responsible for all charges for services provided by this office; I understand that a collection fee will be charged for accounts that require collection procedures. I authorize release of any medical information necessary to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignment with my insurance company.

Medicare Long-term Authorization

I request that payment of authorized Medicare benefits be made to Tru Ortho for any services furnished to me by the above-named doctor. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services.

Medigap Authorization

I request that payment of authorized Medigap benefits be made on my behalf to Tru Ortho for any services furnished to me. I authorize any holder of medical information about me to release any medical information needed to determine these benefits payable for related services.

Form Completion Policy

Effective October 1, 2018 due to the quantity and complexity of forms requested, there will be a $25.00 charge, payable in advance, for the completion of each of the 1st two forms requested. There will be a charge of $40.00 for all subsequent forms.

This includes any form (other than our office forms) needing completion and signature by the physician, insurance, FMLA, disability form, Via Transit Application, etc… Please allow 7-10 business days for completion. The patient portion (including patient signatures) must be filled out in advance prior to submitting it to our office.

All requests for disability forms must be accompanied by a completed job description. This form should be available from your employer. For patients who have had surgery, the “count” restarts with each surgery. The forms will be faxed & mailed to the company requesting the form, with a copy mailed to patient.

The following information must be accompanied with the forms: A Signed Authorization to Release Information, Name of Requesting Company, Contact Name of Company Representative, Address of Requesting Company, Phone and Fax Numbers of the Company.

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Financial Policy

We are committed to providing the best possible care to our patients and feel this goal is best achieved if our patients are aware of our office policies. Your clear understanding of our financial policy is important to our professional relationship.

Timely Payment:

We are doing everything possible to keep the cost of medical care down in our practice. You can help a great deal by eliminating the need for us to bill you. **Full payment is expected at the time of service unless other arrangements have been made in advance.** This especially includes applicable deductibles, co-insurance and co-payments for participating insurance companies. Our office accepts cash, personal checks, American Express, Discover, Visa, and Master Card. You will be given a receipt for all payments. An itemized receipt is available on request, however, please allow us time to select and apply all government required codes.

Benefit packages provided by insurance companies vary from employer to employer. It is vital that you make yourself aware of benefits as stated on *your* policy. We will bill the insurance companies with whom we are contracted, but if we are not paid in a timely fashion, you may be expected to pay the bill in full. Except as provided by such contract or by state law, we are obligated to hold you responsible for all charges.

If you are experiencing financial difficulties, please let our benefit coordinators know. In most cases, a patient who presents this to our office with an urgent problem, will not be turned away because of financial problems.

No Shows:

Please notify us in advance if you are unable to keep your appointment. Appointments not cancelled 24 hours in advance to the scheduled appointment time may be subject to a cancellation/no show fee of $50 per office visit. Extenuating circumstances will be taken into consideration. After three “No Shows” for your scheduled appointments, you will be considered noncompliant and qualify for dismissal from the practice.

Referrals:

If your insurance plan requires a referral in order for you to see a specialist, please contact your primary care physician to confirm that one has been issued to our physicians, and that the referral is on file with your insurance, prior to any appointment.

Medicare:

There are physicians in this group who do not participate in Medicare. Services provided by opted out physicians require a Medicare Private Contract. **This is true whether Medicare is your primary or your secondary insurance.** This is Federal Regulation, so we appreciate your understanding and cooperation with this requirement. Services from participating providers will be billed to Medicare in the standard fashion.

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Returned Checks:

There is a $30.00 charge for any check returned to us from the bank unpaid plus applicable charges added by our outside collection agency. Returned checks are also reported to the Attorney General.

Refunds:

If you believe you are due a refund for an overpayment, please review the following TruOrtho Refund Policy:

1. Your episode of care must be completed prior to any patient refund. All claims within your episode must be finalized with your insurance. This will take at least 90 days for your claim(s) to process. We have no way of pushing this issue. Several factors may further delay the completion of the episode of care. Included are:
   (a) Medical records requests from the insurance companies
   (b) Their assessment if anybody else should be responsible
   (c) Final determination of which insurance is primary vs. which is secondary. It is very common for an insurance company to pay as if they were primary, then decide after the fact that they should have been secondary. In this case they will demand their money back, sometimes more than a year after they have paid. To avoid this, we often have to review, and get the insurance company to verify that they are the primary payor.

2. Please call the office to request a refund. All patient refund requests are directed to the TruOrtho Practice Manager, and not to the billing office. Please do wait until at least 90 days after the service was provided as this is the earliest that the insurance companies might consider the episode of care to be completed.

3. After requesting a refund, and after TruOrtho has determined the episode of care is complete, your account will be audited, and if a credit is verified, a check issued. This process can take an additional 2-4 weeks.

Again, the purpose of the refund policy is to allow time for TruOrtho to submit your claim(s), for your insurance to process your claim(s) and to issue proper payments and EOBs to TruOrtho. Some instances involve second level appeal, as well as refund requests from insurance companies on previously processed claims that require more time and review. We do wish that we had more control over these issues, but the insurance companies both work on their own time and can be quite fickle.

Collections:

All fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered past due. In this case, we will make every effort to contact the person responsible for the delinquent balance and arrange an equitable payment schedule. However, if no effort is made to pay the balance due, it may be sent to an outside collection agency. In this situation, the patient may be asked to seek medical care elsewhere.

Payment arrangements on outstanding balances will be carried no longer than a four (4) month period.

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1. I have read and understand the TruOrtho's financial policy.
2. I agree to keep TruOrtho accurately informed of my insurance status and to assign benefits to TruOrtho if necessary. I also understand that should I fail to do so, I will be responsible for payment in full immediately.
3. I agree to keep TruOrtho accurately informed of my current mailing address and telephone numbers.
4. I agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any processing fees in addition to the original amount due.

HIPPA E-mail Authorization

1. HIPAA stands for the *Health Insurance Portability and Accountability Act*, which was passed by Congress in 1996 to establish privacy and security protections for health information.

2. Information stored on our computers is commonly encrypted to prevent unauthorized viewing or disclosure.

3. Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not encrypt email.

4. **When we send you an email or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it because it is transmitted over the Internet. Once the email is received by you, someone may be able to access your email account and read it or delete it.**

6. Email is a popular and convenient way to communicate for many people, so the U.S. Department of Health and Human Services provided some guidance on email and HIPAA, and issued regulations related to HIPAA and electronic disclosures.

7. The information is available on the U.S. Department of Health and Human Services website http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html

8. The guidelines and regulations state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Patient Responsibility Agreement for Controlled Substances Prescriptions

Controlled substance medications (*ie* narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled and monitored by the local, and state, as well as the federal government. The conditions outlined here are designed to keep both

patient and physician within the bounds of applicable laws. By accepting a prescription for a controlled substance, I understand and agree to the following:

1) I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, stolen, or if I "run out early", I understand that it will not be replaced.
2) Concerning refills of controlled substances, I understand that:
    a. We will make every effort to refill these medications if they are being used in an appropriate manner before we leave for the day. We cannot guarantee that all appropriate refills will be called in the same day. **Please allow 48 hours.**
    b. Refills will not be made on an "emergency" basis such as **Friday after 12:00 PM** or **over the weekend.**
3) I will not obtain controlled substances from any other physician or any other person with a prescription for the same or similar medication.
4) I understand that the use of controlled substances may impair my ability to operate motor vehicles or heavy equipment. It is my responsibility to comply with the laws of the state while using controlled substances.
5) I understand that if used according to prescription, the true addictive potential of these medications is small, but tolerance or other dependency may develop. These may be managed by adjustments in dosage or tapering of the medications. In some cases, referral to a pain management physician may be necessary.
6) I understand that controlled substances do not "mix well" with alcohol.
7) I agree to have all of my prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the prior pharmacy will be so notified by this office. The pharmacy that I have selected is:

8) I understand that if I violate any of the above conditions, my prescriptions for controlled substances will be terminated immediately. I further understand that such violation may be reported to all of my physicians, to medical facilities, to pharmacies, and if required by law, to appropriate authorities.

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

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4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. I understand that my insurance carrier will have access to my medical records for quality review/audit.
7. I understand I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit. I also understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
8. I understand that this document will become a part of my medical record.

By signing this form, I attest that I have personally read this form and full understand and agree to its content; have had my questions answered to my satisfaction; and am located in the state of Texas and will be during my telemedicine visit.

Notice of Privacy Practices Receipt

Effective Date: 10/01/2018

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

If you have any questions about this Notice, please contact:

Tru Ortho, PLLC

Who will follow this Notice?

- Tru Ortho, PLLC providers
- All Tru Ortho, PLLC employees

We understand that medical information about you and your health is personal and are committed to protecting this information. When you receive care at Tru Ortho, PLLC a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

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This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as “medical information”). It also describes your rights and our obligations regarding the use and disclosure of medical information.

Our Responsibilities

Tru Ortho, PLLC shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restrictions; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Tru Ortho, PLLC will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputational or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

The Methods In Which We May Use And Disclose Medical Information About You.

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- **For Treatment.** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialist to whom you are referred for follow-up care.
- **For Payment.** We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.
- **For Health Care Operations.** We may use and disclose medical information about you for office operations. These uses, and disclosures are necessary to run Tru Ortho, PLLC in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluateion of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.
- **Appointment Reminders.** We may use and disclose medical information in order to remind you of an appointment. For example, Tru Ortho, PLLC may provide a written or telephone reminder that your next appointment is coming up.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special

approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal or Texas laws or regulations.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you to medical law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Sale of Practice.** We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

Special Situations.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
    - To prevent or control disease, injury, or disability;
    - To report reactions to medications or problems with products;
    - To notify people of recalls of products they may be using;
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or conditions; and
    - To notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility, or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes.** If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to court or administrative order.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
    - In response to a court order or subpoena; or
    - If Tru Ortho, PLLC determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates.** If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures.** Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided that it is in writing and we have not already relied on the authorization.

Your Rights Regarding Medical Information About You.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.

  To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer for Tru Ortho, PLLC. If you request a copy of the information, Tru Ortho, PLLC may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records. Tru Ortho, PLLC may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Tru Ortho, PLLC will review your request and denial. The person conducting the review will not be the person who denied your request. Tru Ortho, PLLC will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information maintained about you is incorrect or incomplete, you may ask Tru Ortho, PLLC to amend the information. You have the right to request an amendment for as long as the information is kept by Tru Ortho, PLLC.

  To request an amendment, your request must be made in writing and submitted to Tru Ortho, PLLC. In addition, you must provide a reason that supports your request.

  Tru Ortho, PLLC may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Tru Ortho, PLLC may deny your request if you ask us to amend information that:

    - Was not created by Tru Ortho, PLLC, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by Tru Ortho, PLLC;
    - Is not part of the information which you would be permitted to inspect and copy; or

    - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.

  To request this list, you must submit your request in writing to Tru Ortho, PLLC's office manager. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Tru Ortho, PLLC will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Tru Ortho, PLLC uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information Tru Ortho, PLLC discloses about you to someone who is involved in your care or the payment for your care.

Tru Ortho, PLLC is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Tru Ortho, PLLC has been paid out of pocket in full. Should Tru Ortho, PLLC agree to your request, Tru Ortho, PLLC will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Tru Ortho, PLLC. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit Tru Ortho, PLLC's use and/or disclosure; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that Tru Ortho, PLLC communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Tru Ortho, PLLC contact you only at work or by mail

  To request that Tru Ortho, PLLC communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Tru Ortho, PLLC will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes to This Notice.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

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Complaints.

If you believe your privacy rights have been violated, you may file a complaint with Tru Ortho, PLLC or with the Office for Civil Rights, U. S Department of Health and Human Services. To file a complaint with Tru Ortho, PLLC, contact the Privacy Officer at (210) 878-4116. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

Secretary of Health & Human Services

Region VI, Office for Civil Rights

U.S Department of Health and Human Services

1301 Young Street, Suite 1169

Dallas, TX 75202

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.