Authorization for Treatment/Release of Information

Central Texas Pulmonary & Critical Care Associates, PA
Georgetown Pulmonary Associates, PA

Consent to Treatment:

The patient and/or authorized representative hereby gives consent to any and all medical treatments which may deem advisable by the physician(s) of Georgetown Pulmonary Associates, PA.

Authorization for Release of Confidential Information:

I hereby authorize Georgetown Pulmonary Associates, PA to release medical information contained in my/the patient's record to any insurance carrier, employer or other third party intermediary utilized by the patient for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges, as well as any referring physician for continuity of care. Medical records released may include any diagnostic or therapeutic information of visits and/or procedures performed in the office. Unless initialed below the records may include any confidential information regarding:

Alcohol/Substance abuse, Mental Health, HIV _____

According to the Health Insurance Portability and Accountability Act of 1996 (HIPPA):

The patient's medical records may not be furnished to, and the medical condition of the patient may not be discussed with any person other than the patient, the patient's legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient's written authorization.

Please list anyone you authorize to discuss your care. For additional space please write on the back.

Name & Relationship_____Name & Relationship_____

Is there anyone you do not wish the office to speak with regarding your care?

No _____ Yes _____ (If Yes, list the name and relationship: _____)

Assignment of Insurance Benefits:

I assign payment directly to Georgetown Pulmonary Associates, PA, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment. I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue insurance payment for any claims unpaid after thirty (30) days. If, after forty-five (45) days, the claim remains unpaid, I understand the balance will be due from me.

Medicare Patients

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Georgetown Pulmonary Associates, PA to release to the Health Care financial Administration or its carriers or intermediaries any information needed for this or related Medicare claims. I hereby authorize payment directly to Georgetown Pulmonary Associates, PA for medical benefits and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment.

Patient Agreement:

I understand that Georgetown Pulmonary Associates, PA is not in the business of extending credit. Therefore, it is the policy of Georgetown Pulmonary Associates, PA to require payment in full at the time of service. If unable to pay balance due in full at the time of service, I agree to make prior arrangements with the Billing Department.

I understand that I am financially responsible for my account with Georgetown Pulmonary Associates, PA, regardless of my insurance benefits.

_____ _____

Patient Signature **Date**

_____ _____

Patient/Representative Name (Printed) **Relationship to patient**

Cancellation & Reschedule Policy

Central Texas Pulmonary & Critical Care Associates, PA
Georgetown Pulmonary Associates, PA

We value your time and do our best to run on schedule. With that in mind, we ask that you **arrive 15 minutes prior** to your appointment so that we may get you checked in with our front desk staff. This will allow you to be seen by your provider closest to your scheduled appointment time. Due to the high volume of people using our medical campus, **please allow additional time to find a parking place**.

If you are **more than 10 minutes late** to an appointment your appointment may be rescheduled and the appropriate fee(s) below may apply.

If you must cancel or reschedule an appointment **please call at least 24 hours prior to the appointment. 24 hour notice is defined as one business day.** Messages left over the weekend are **not** considered sufficient notice. If you miss or cancel two appointments without giving 24 hour notice you may be unable to schedule any further appointments.

Failure to cancel or reschedule without 24 hour notice will result in a cancellation fee applied as follows:

New Patient Consult: $50.00
Follow Up Visit: $25.00
Pulmonary Function Testing (single): $25.00
Pulmonary Function Testing (multiple): $50.00
Office/Hospital Procedure: $100.00

You are responsible for this fee; it cannot be billed to insurance for reimbursement. No further appointments will be scheduled until this cancellation fee has been reconciled.

I have read, understand, and agree to cooperate with the cancellation policy listed above.

_____ _____

Patient Signature **Date**

_____ _____

Patient/Representative Name (Printed) **Relationship to patient**

Zero-Tolerance Policy

Central Texas Pulmonary & Critical Care Associates, PA

Georgetown Pulmonary Associates, PA

We aspire to provide a safe and welcoming environment for all, with mutual respect between ourselves and our patients. We have a zero-tolerance policy for the following behavior:

1. Recording of any type is prohibited in this office.
2. Verbal abuse, malicious or harmful statements, profanity, or disrespect toward our providers, staff, or another person in the clinic.
3. Any form of sexual harassment.
4. Discriminatory comments and/or actions.
5. Intimidation tactics and/or threats.
6. Public disclosure of another's private information.
7. Failure to comply with requests from our staff.
8. Suspicion of being under the influence of alcohol or behavior-altering drugs.

Should your behavior become problematic, we reserve the right to discontinue services immediately.

This policy is strictly enforced, and non-compliance will result in corrective measures, which may include termination of services from our practice, being asked to leave the property, and potential involvement by law enforcement.

I have read, understand, and agree to abide by the zero-tolerance policy listed above.

_____

Patient Name (Printed)

_____ _____

Patient Signature **Date**

FINANCIAL POLICY

Central Texas Pulmonary & Critical Care Associates, PA
Georgetown Pulmonary Associates, PA

In compliance with the Federal Consumer Protection Act, Georgetown Pulmonary Associates, PA is furnishing you with information regarding your financial responsibilities.

We are pleased that you have chosen our office for your healthcare needs. We'd like to familiarize you with how our services are billed, which insurance claims we file on your behalf, when we request payment from you, and our credit policies. Please take the time to read this policy and if you have any questions please ask to speak to someone in our billing department.

Please note that due to a new Federal Law you must present our office with a valid Driver's license, in which your photo must look like you, and your name MUST match the name on the insurance cards you give us. If these items do not match we will refuse to file your insurance, and you will have to pay, in full, services rendered. This has been implemented to protect you from insurance fraud. We have no choice in the matter.

If you have Medicare primary: You have a deductible to pay at the beginning of each year. Once that deductible is met, Medicare only pays 80% of the allowed charges. There is a 20% coinsurance due. If you do not have a secondary insurance, or your secondary insurance does not cover the 20% in full, you will be responsible for that balance at the time services are rendered.

If you have an indemnity plan which requires a deductible and co-insurance you are responsible for payment of your deductible and/or co-insurance in full at the time your services are rendered. If you have co-payment plan all co-pays are due at the time services are rendered.

Please note we collect money based on verbal, faxed, or Internet communication with your insurance; if there is a miscommunication by your carrier and the correct amount was not collected, you will receive a bill for the balance. Overpayments will not be refunded until all outstanding claims have been processed by insurance and all balances settled.

It is always your responsibility to understand the coverage of your insurance policy and its referral/authorization processes.

Please understand that our office cannot accept responsibility for payment or nonpayment on your insurance claims. Questions about coverage and benefits should be directed to your insurance company.

BILLING POLICY: Any invoices received from our office are due immediately upon receipt. If for any reason you cannot pay the bill in full, we ask that you contact our billing office to set up a payment plan. See next paragraph for our credit policy.

CREDIT POLICY: We do not offer in-house payment plans for deductibles - all deductibles must be paid in full at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express. Please ask to speak to someone in our billing department for these arrangements.

COLLECTION POLICY: All charges you have been billed for are due no later than 30 days of receipt of your billing statement. I understand that an interest rate of 1.5% may apply to any invoice over 30 days old. If you fail to respond to the billing, or fail to cooperate with the terms of your payment plan, your account may be turned over to an outside agency for resolution. If this occurs, you agree to be legally responsible for any and all collection fees which include, but are not limited to, a 33% agency fee (an additional 33% of what you owe) along with any and all attorney and/or court fees.

To avoid problems due to delayed mail, it is your responsibility to notify our office of any changes in your name, address, phone number, or insurance coverage.

I have read, understand, and agree to cooperate with the financial policy listed above.

Patient Signature _____ **Date** _____

Patient/Representative Name (Printed) _____ **Relationship to patient** _____

HIPAA Acknowledgement Form

Central Texas Pulmonary & Critical Care Associates, PA
Georgetown Pulmonary Associates, PA

I,_____, understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in-office or on the office website <http://www.txpulmonary.com>). I have the right to review the *Notice of Privacy Practices* prior to signing this acknowledgement. I understand that this organization has the right to change its *Notice of Privacy Practices* without notice, and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, this organization restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent, in writing, at any time, except to the extent that the organization has taken action relying on this consent.

By supplying my home phone number, mobile phone number, e-mail address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided by me.

_____ _____

Patient Signature **Date**

_____ _____

Patient/Representative Name (Printed) **Relationship to patient**

For office use only

We attempted to obtain written acknowledgement of our *Notice of Privacy Practices*; however, acknowledgement could not be obtained because:

- □ Individual refused to sign.
- □ Communication barriers prohibited obtaining the acknowledgement.
- □ An emergency situation prevented us from obtaining acknowledgement.
- □ Other (please specify) _____
  _____