

# **Oatka Family Medicine P.C.**

## **Financial and Missed Appointments Policy**

Thank you for choosing Oatka Family Medicine as your primary care provider. We are committed to providing you with quality and affordable healthcare. To address any questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided on your demographic form. A copy will be provided to you upon request.

1. **Insurance.** We are participating in most local insurance plans, including Medicare and Medicaid if you are not insured by a plan we do business with payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All copayments must be paid at the time of service. Deductibles are billed to you after your insurance company processes the claim. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copayment at each visit. Payment can be made in the form of cash, credit, or check.
3. **Non-covered services.** Please be aware that some –and perhaps all– of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Some examples include certain immunizations and Mole treatments.
4. **Proof of insurance.** At each visit we must obtain a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Coverage changes.** If your insurance changes please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
6. **Nonpayment.** If your account is over 90 days past due you will start incurring late fees at a rate of \$10 per month. Partial payments will not be accepted, unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members maybe discharged from this practice. If this is to occur you will be notified by regular and certified mail that you have

- 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.
7. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you.

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**Signature of patient or responsible party**

**Date**

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**Oatka Family Medicine P.C.**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ½**

I hereby give my consent for Oatka Family Medicine PC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (the notice of privacy practices provided by the practice describes such uses and disclosures more completely and is continually posted in the patient handbook in the waiting room at Oatka Family Medicine .

I have the right to review the notice of privacy practices prior to signing this consent. Oatka Family Medicine reserves the right to revise its notice of privacy practices at anytime. A revised notice of privacy practices may be obtained by forwarding a written request to Dawn Lee, RN at Oatka Family Medicine, 5619 East Main St. Rd. Batavia, NY 14020.

With this consent, Oatka Family Medicine may contact me in the following ways in reference to any items that assist the practice carrying out treatment, payment, and healthcare operations, such as appointment reminders Insurance items and any calls pertaining to my clinical care, including laboratory test results, among others: please check

- At my home or cell phone in person
- At my home or cell voicemail
- In writing to my home address
- At my personal email address
- Through text messaging (for appointment reminders only)

By signing this form, I am consenting to allow Oatka Family Medicine to use and disclose my PHI to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent, or later revoke it, Oatka Family Medicine may decline to provide treatment to me.

Signed by: \_\_\_\_\_  
 Signature of Patient or Legal Guardian      Date      relationship to patient

\_\_\_\_\_  
 Print Patient's Name      Print Name of Legal Guardian, if applicable

Patient/ guardian must be provided with a signed copy of this authorization form

**Oatka Family Medicine P.C.**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 2/2**

I hereby give my consent for Oatka Family Medicine P.C. to discuss any and all issues related to my healthcare, including PHI with the following individuals. This consent may be revoked at any time by requesting so in writing or by completing a new HIPAA form.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian      Date      relationship to patient

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Legal Guardian, if applicable

Oatka Family Medicine, PC

5619 East Main St. Rd. Batavia, NY 14020 Phone (585)201-7055 Fax(585)219-6140

Patient\_\_\_\_\_

Address\_\_\_\_\_

Date of birth\_\_\_\_\_

Oatka Family Medicine is authorized to receive from:

Recipient/Discloser Name\_\_\_\_\_

Phone\_\_\_\_\_ FAX\_\_\_\_\_

I authorize release of the following medical records:

Medication List, Problem List, Last Year of Labs, all Radiology Reports, all Consultant Reports, EKG's, Immunization Record, Growth Curve

Or

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This includes permission to release Potentially Sensitive information which may include information concerning my treatment of mental illness, HIV, alcoholism, drug use, venereal disease, sexual assaults, abortions, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

I release Oatka Family Medicine PC, and the Recipient/Discloser listed above from all responsibilities or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

Patient Signature\_\_\_\_\_ Date\_\_\_\_\_

Witness Signature\_\_\_\_\_ Date\_\_\_\_\_

**OATKA FAMILY MEDICINE P.C.**

**NEW YORK STATE DEPARTMENT OF HEALTH REQUIRED OFFER OF H.I.V. TESTING**

Your healthcare provider is required to make an offer of HIV testing to all patients between the ages of 13 and 64 regardless of apparent risk. You are strongly encouraged to accept testing since, as with other medical screenings, it may provide you with important information about your health and give you what you need to make good decisions for staying healthy.

Yes, I accept the offer of HIV testing.

No, I don't want an HIV test today.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Patient or person authorized to consent