FINANCIAL POLICY

Arkangel Endocrinology and Diabetes, PLLC is committed to the success of your medical treatment and your well-being. Payment of your medical bill is part of your treatment and care. Our office participates with numerous insurance companies and managed health care programs. We require you to show your insurance card(s) at every visit. While we gladly bill your insurance companies for your services, it is important for the patient to be familiar with the guidelines of their insurance plan requirements regarding authorizations, deductibles, co-payments and other vital requirements. A copy will be provided to you upon request.

Co-payment

The entire amount of co-payment is due on the day of service, or a $10.00 surcharge will be applied. Our office will submit a claim to your Primary and Secondary insurance as a courtesy, but you are ultimately responsible for the payment, regardless of your insurance coverage. Should you have a third (tertiary) insurance plan, it will be your responsibility to submit those insurance claims. Please check with your insurance company for requirements. **If you are enrolled in an HMO that requires a referral, our office must have a referral prior to your appointment**. If we do not have the referral at your appointment time, your appointment will be rescheduled for another day. All charges determined to be your responsibility by your insurance company shall be paid in full upon receipt of the first statement. Please notify the Billing Department if assistance is needed to meet your financial obligation. Patient balances past 120 days with no payment or payment arrangements will be turned over to a collection agency. In the event that we receive a returned check, a fee of $35.00 will be charged to your account, and payment in full is due upon receipt of your statement. Arkangel Endocrinology and Diabetes, PLLC strives to offer our patients excellent endocrinology care and assist the patient to receive maximum benefit from their insurance plan.

Payment Methods

Payment is expected at the time services are rendered. We accept a variety of payment methods including cash, check, money order, or credit card (Visa, MasterCard, American Express, PayPal, and Discover). Recurring payment plans are available with management approval, if payments are missed, a surcharge of $25.00 will be applied to your account.

Insurance Information

We must emphasize that your health is our primary concern, regardless of your insurance. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitation or other benefit restrictions that you may have PRIOR to your appointment. We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Most insurance companies do not cover 100% of the cost of services and there is a portion that is your responsibility. There are several patient responsibility components that may apply to an insurance payment:

Co-pay – A set dollar amount per office visit that is the patient's responsibility.

Co-insurance – A percentage of the charge that is the patient's responsibility.

FINANCIAL POLICY

Deductible – A set annual amount that the patient is responsible for paying prior to his or her insurance making a payment.

Because of the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance. All co-payments, co-insurance, and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. To bill your insurance accurately and in a timely manner, we will need assistance from you. We ask that you provide our office with accurate demographic information (address, phone number, e-mail etc.) and proof of insurance. All patients will be required to show proof of insurance and a Government issued Photo ID.

Insurance Changes

If there are any changes in your insurance, you are required to provide that information to our office. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the resulting balance.

Managed Care: All Managed Care (i.e., HMO, PPO, POS)

Co-payment, co-insurance, and deductible amounts are due at the time of check-in.
If your insurance plan requires a referral authorization from a primary care physician you are responsible for obtaining approval from your PCP prior to treatment. If you request an office visit or procedure without a referral authorization, your insurance plan may deem this as non-covered treatment and you will be responsible for the charges.

Medicare

We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the yearly deductible. You are responsible for 20% of Medicare allowed amount unless you have secondary insurance coverage. All co-payments, co-insurances, or deductibles are due and payable at the time of service. Secondary and Tertiary Plans We will bill your secondary and, if applicable, tertiary insurance as a courtesy. If you have supplemental insurance to cover the portion of the charges that Medicare or your primary insurance carrier does not pay, please provide us with a copy of this insurance card.

Prior Authorization

Please remember that it is up to you to understand the requirements of your individual insurance plan and know whether prior authorization from your insurance company is required.

Non-covered Services

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Cash Patients

Cash patients are accepted at an already-discounted cash pay rate. All uninsured patients will be required to pay in full at time of treatment.

Nonpayment

Please be aware that patient accounts over 120 days without satisfactory payment will be turned over to a collection agency and patients will face possible termination from the practice.

FINANCIAL POLICY

Returned Checks
A $35.00 fee will be charged for any returned checks. We will be unable to accept your checks for any services thereafter.

Missed Appointments/ Late Arrivals
In an effort to provide our patients with quality, efficient care, it is necessary for you to attend appointments as scheduled. Compliance with your prescribed plan of care is critical for success in your healthcare. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 (twenty-four) business hours in advance to avoid a service charge - **$50.00 for appointments**, Patients who habitually fail to keep scheduled appointments and do not give a 24 (twenty-four) hour cancellation notice may face treatment termination. Any patient later than 20 (twenty) minutes past his or her original appointment time may be asked to reschedule as that appointment has been missed.

Medical Records
Medical records requests will be processed upon receipt of a signed medical release. Please note: A fee will be collected to produce medical records. A healthcare provider or hospital can request the records for continuity of care at no cost. Please be aware that billing records are a part of your medical record and will also require this form. We can mail, fax or secure e-mail your records. In addition, you may retrieve it from the patient portal on our website at no cost.

Account Billing Questions and Refunds
Questions or concerns regarding your account or insurance claim should be directed to billing office staff. If you feel an error has been made in your statement or if you have any questions or concerns please contact our office. By signing below, you agree and understand all of the information stated above, future phone, recurring payments and/or payment plan set-up to our mutual satisfaction.

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Printed Name (Patient or Responsible Party)

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Signature (Patient or Responsible Party)

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Date of Birth (Patient or Responsible Party)

____

Date

OFFICE POLICIES

FINANCIAL POLICY

For detailed "Financial policy" look up and sign dedicated, separate document. Please bring your insurance card to each visit – if your insurance changes, please confirm that our office is contracted with your new plan. If your insurance requires co-pay for office service – it is due at the time of the service. We accept cash, checks and credit cards. Your appointment will be cancelled if you are not prepared to pay the co-pay upon arrival. If your insurance requires an authorization or a referral – it is YOUR responsibility to be aware of this and obtain the referral from your primary care physician. If no referral has been received 48 hours prior to scheduled appointment, it will be rescheduled or cancelled.

CANCELLATION POLICY

Patients are seen by appointments only and appointment time is reserved specifically for you – when you fail to show or cancel with less than 24-hour notice, it is not only a financial loss to the practice, but it is also a time that we could offer to another patient that needed to be seen. For this reason, if you fail to show to the appointment or cancel with less than 24-hour notice, we will assess **$50.00** fee to your account. Fee will be waived for unforeseen circumstances.

PATIENT CARE AND SERVICES/REFILLS

Phones will be answered from 7:30 AM to 4:00 PM, with break for lunch 12PM to 1 PM.

- Refills are handled during office hours only.
- To facilitate the refill, pharmacy should send us electronic or fax request for refill.
- Patient may also request refill via patient's portal.
- Please allow 2 business day to fulfill the request and longer, if medication requires prior authorization from the insurance (patient can verify with insurance how long it takes to process the request and make decision regarding coverage)
- If you need insulin pump or sensor supplies, please have your usual provider fax the order form (standard order form provided by vendor) to our office, so we can fill out and sign the form and provide all supporting documentation.

AFTER-HOURS/ OUT OF OFFICE COVERAGE

After hours care: **If you have a life-threatening issue, please call 911.**

For non-urgent maters, preferred way of communication is patient portal – you can sign up for it at any time. Please note that portal is not a replacement for office visit, and it serves only for quick communication like – appointment request, medication request, records request, lab work request etc. For all non-endocrine issues please contact your primary care provider.

LAB WORK RESULTS

Please allow 5-14 business days for routine lab work results delivery – we strive to deliver results as soon as it is possible – due to heavy load of laboratory data and some of the labs requiring longer processing time it may take longer to get results back. Urgent/ STAT labs will be reviewed as soon as received.

RECORDS REQUEST/ FORMS

If you change the office/ physician, we will be happy to send records electronically free of charge directly to the provider/office– please sign the release of records form and provide fax number. If you are requesting a copy of your records, a fee will be collected, you may log in to the patient portal to obtain any records at no charge. Your primary care physician is the best resource to help you to complete forms including but not limited to FMLA, disability etc. Our office reserves the right to charge $50.00 in advance for form completion.

OFFICE POLICIES

STANDARD OF CONDUCT

At Arkangel Endocrinology and Diabetes, PLLC we embrace culture of mutual respect which is expected of everyone including doctors, staff, patients, and families. Failure of our staff to follow this policy will result in corrective action. Offensive or demeaning behavior by patient or family member toward our staff or physicians will result in our withdrawal from patient's medical care.

Your signature signifies your understanding and willingness to comply with these office policies.

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Printed Name (Patient or Responsible Party)

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Signature (Patient or Responsible Party)

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Date of Birth (Patient or Responsible Party)

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Date

PRIVACY POLICY

This is required by the Privacy Regulations created because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you have any questions regarding this notice or our health information privacy policies, please contact our office.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and our responsibilities to help you.

- Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. We may say “no” to your request, but we’ll tell you why in writing within 60 days.
- Request confidential communications: You can ask us to contact you in a specific way (for instance, you may ask that we contact you at home, rather than work) or to send mail to a different address. We will say “yes” to all reasonable requests.
- Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- Get a list of those with whom we’ve shared information. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer at Arkangel Endocrinology and Diabetes, PLLC at the practice address. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OUR USES AND DISCLOSURES

The following circumstances may require us to use or disclose your health information to:

- Treat you: We can use share your health information with other health professionals who are treating you.
- Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.
- To public health authorities and health oversight agencies that are authorized by law to collect information - www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official.

PRIVACY POLICY

- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
- If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have reviewed this copy of Notice of Privacy Practices and I consent to the use and disclosure of my medical information as set forth herein. (A copy of the Notice of Privacy Practices can be requested.)

____

Printed Name (Patient or Responsible Party)

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Signature (Patient or Responsible Party)

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Date of Birth (Patient or Responsible Party)

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Date

TELECOMMUNICATION CONSENT

I authorize Arkangel Endocrinology and Diabetes to use telecommunication in determining my delivery of results, diagnosis, consultation, treatment, and transfer of medical data through interactive audio, video, or data communication. (Examples: Video Calls, Telephone Calls, Patient Portal)

Benefits:
-Improved access to medical care
-Lower cost and greater efficiency to receive medical evaluation and management
Risks:
-Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies
- In very rare events, security protocols could fail, causing a breach of privacy of your personal health information. (Please Note: Security features/protocols are enabled to prevent privacy breaches)
-Telemedicine physician cannot utilize the senses of touch and smell to assist in diagnosis, treatment, or therapy

Alternatives:
Presenting to office for all communication

1. I hereby consent to receiving Telemedicine services. I understand that Providers offer Telemedicine services, but that these services do not replace the relationship between me and the doctor. I also understand it is up to the doctor to determine whether my needs are appropriate for a Telemedicine encounter.
2. I understand that federal and state law requires health care providers to protect the privacy and the security of my personal health information. I understand that Arkangel Endocrinology and Diabetes, PLLC will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that Telemedicine may involve electronic communication of my personal health information to other medical practitioners who take part in my care.
3. I understand there is a risk of technical failures during the Telemedicine encounter beyond the control of doctor(s)/Staff. I agree to hold Doctor(s)/Staff harmless for delays in evaluation or for information lost due to such technical failures.
4. I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine during my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate access to the service at any time for any reason or for no reason and will be required to sign a new form. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the Doctor(s)/Staff are not able to connect me directly to any local emergency services.
5. I understand the alternatives to Telemedicine consultation, such as in-person services are available to me, and in choosing to participate in a Telemedicine consultation.
6. I understand video images and audio recordings of me may be captured and stored electronically. I understand that these recordings may be later viewed and used for purposes of evaluation. I understand and consent to the use of these images and audio recordings for the Telemedicine consultation and, potentially, evaluation, education, charting and billing.
7. I understand that I may expect the anticipated benefits from the use of Telemedicine in my care, but that no results can be guaranteed or assured.
8. I understand that my personal health information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the consultation other than the Provider to operate the Telemedicine technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details as desired by me.
9. I understand that my insurance will be billed for my Telemedicine Consultation (Audio, Video, or both) and I am solemnly responsible for any copay's, deductibles or remaining balances that insurance does not cover.

______________________________________ ______________________________________
Printed Name (Patient or Responsible Party) **Date of Birth** (Patient or Responsible Party)

______________________________________ _____________
Signature (Patient or Responsible Party) **Date**