

ATLANTA HAND SPECIALIST/ATLANTA HAND THERAPY

FINANCIAL POLICY

Thank you for choosing Atlanta Hand Specialist/Therapy as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign and return to us prior to your treatment.

- All patients are to provide accurate and complete personal and insurance information prior to being seen by the doctor. You will need to provide a picture ID and your insurance card.
- All applicable co-pays, personal balances, both current and prior, are due at the time of service.

Regarding Insurance

We participate on most insurance plans. Read and understand your insurance policy. It is **your responsibility** to understand the rules and terms of your insurance. We will **not** explain coverage, benefits, or guarantee our participation status in your plans. You need to obtain this information, **prior to your visit**. Your policy is a contract between you and the insurance carrier. Read it, understand it and ask questions. **DO NOT ASSUME YOUR POLICY AUTOMATICALLY COVERS EVERYTHING.** Even different policies from the same insurance company can have different requirements. It is **YOUR** responsibility to know what your policy covers and what it does not. Always carry your insurance card with you. You will need it for all office visits and may need it in case of an emergency. Some insurance carriers require we verify your coverage for each office visit. Without this information, we may have to reschedule your appointment or you may have to pay at time of service. Some carriers require a referral or prior authorization from you primary care provider. It is **YOUR** responsibility to obtain this referral. **IF YOU DO NOT HAVE A REFERRAL OR PRIOR AUTHORIZATION, YOU WILL BE RESPONSIBLE FOR PAYMENT OR WE WILL RESCHEDULE YOUR APPOINTMENT.**

Usual and Customary Rates

We are committed to providing the best treatment for our patients. We charge what we believe to be reasonable and customary fees, for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

Past Due Accounts

Over due accounts will be referred to a **collection agency**. Legal fees that we pay to secure past due balances will be added to your account.

Returned Checks

For checks returned to us for non-sufficient funds by your bank, we will charge a fee of \$30.00.

Insurance Denials

In the event that any date of service is denied by the insurance carrier for ineligibility or no referral, the remaining balance will be turned over to patient responsibility.

Insurance Non-Payment

If a claim is forty-five (45) days old and there has been no response from the insurance carrier, the balance due will be turned over to patient responsibility for payment.

Please contact our Billing Department if you have any questions or concerns at 770-333-7888.

I have read the Financial Policy and I understand and agree to the Financial Policy.

Print Name

Signature

Date

3968 Felton Hill Road, SW •
Suite 100 and 220
Smyrna, Georgia 30082

3903 South Cobb Drive • Suite 200
Smyrna, GA 30080

6025 Professional Pkwy. • Suite 200
Douglasville, GA 30134

SPECIALIST: (770) 333-7888
THERAPY: (678) 214-6960

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare the Atlanta Hand Specialist/Therapy originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or health care operations.

I understand that Atlanta Hand Specialist/Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or by revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Atlanta Hand Specialist/Therapy reserves the right to change their notice and practice and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Atlanta Hand Specialist/Therapy change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

Patient's/Guardian's Signature (if minor, enter relationship to Patient) **Date**

FOR OFFICE USE ONLY

[] Consent received by _____ on _____.
[] Consent refused by patient and treatment refused as permitted.

POLICY AND PROCEDURES

NOTICE OF HEALTH INFORMATION PRACTICES

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

Introduction

At Atlanta Hand Specialist/Therapy, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose this information. It also describes your rights as they relate to your protected health information. This Notice is effective September 21, 2009 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Atlanta Hand Specialist/Therapy a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Atlanta Hand Specialist/Therapy, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
 - Inspect and copy your health record
 - Amend your health record
 - Obtain an accounting of disclosures of your health information
 - Request communications of your health information by alternative means or at alternative locations
 - Request a restriction on certain uses and disclosures of your information
 - Revoke your authorization to use or disclose health information except to the extent that action has already been taken
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Our Responsibilities

Atlanta Hand Specialist/Therapy is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to 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 restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures including in the authorization.

For More Information or to Report a Problem

If you have any questions and will like additional information, you may contact the practice's Privacy Officer, Jennifer Bell at 770-333-7888.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

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3968 FELTON HILL ROAD, SW
SUITE 100 & 220
SMRYNA, GA 30082

3903 SOUTH COBB DRIVE
SUITE 200
SMYRNA, GA 30080

6025 PROFESSIONAL PKWY.
SUITE 200
DOUGLASVILLE, GA 30134