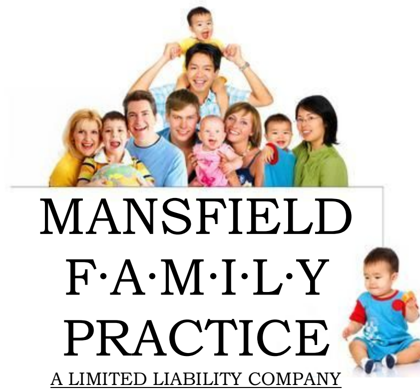

Patient Expectations and Payment Policy

Patient Expectations

We believe the best healthcare outcomes are based on mutual trust between patient and physician. We believe patients and families are partners in ensuring that the best possible care is provided in a healthful, safe environment. **We count on you to participate in your care in the following ways:**

- To the best of your knowledge, provide accurate and complete information about your present symptoms, past illnesses, allergies, hospitalizations, medications and other matters relating to your health.
- Ask questions if you do not clearly understand the proposed plan of care and what is expected of you.
- Arrive at least 10 minutes before your appointment to ensure you are seen on time.
- Keep appointments. When you are unable to do so for any reason, notify the office reception staff in advance. A **$25** fee may be applied for any visit missed without proper notice. Excessive missed appointments may result in discharge from the practice.
- Treat other patients and staff with consideration and respect.
- Be respectful of other patients' right to privacy.
- Be honest with the doctors & other health-care workers.
- Follow the treatment plan agreed upon.
- Provide accurate insurance information and promptly pay balances not covered by your insurance.
- Understand the requirements of your own health insurance. (We will do our best to assist you as we are able however, it is virtually impossible for us to keep all of the different health plans straight, but we sure try!)
- Pay your co-payment at the time of your appointment.
- Understand how your pharmacy plan works.
- If you have a life threatening situation, call 911 or go to the nearest emergency room.

Mansfield Family Practice will try to do everything we can to accommodate you and your family. **In an effort to set reasonable expectations, Mansfield Family Practice will:**

- Introduce ourselves.
- Greet you in a pleasant, professional manner.
- Take you to a neat, orderly exam room and be prepared for your exam.
- Answer your questions or let you know where you can get answers.
- **Fill or refill prescriptions within twenty-four (24) hours**. Refills may take longer if they are called in afterhours or on weekends.
- Process any requested forms you may need for school/camp physicals, disability, FMLA, etc. within 7 days. **A form completion fee may apply of $25**

- Do our best to find you a suitable appointment date and time. *Please note that most forms you need for schools or work require an examination*
- Provide prompt and accurate billing
- Keep all your records and communications concerning care and treatment confidential.
- Handle routine medical questions during normal business hours. Every effort will be made to return your call in a timely manner, however, *you may need to be seen in our office to properly diagnose and treat a problem.* We can only truly treat all medical problems in person.

Payment Policy

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- **Insurance.** We participate in most insurance plans, including Medicare. 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.

- **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

- **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.

- **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance 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.

- **Claims submission.** We will submit your claims 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. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

- **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.

- **Nonpayment.** If your account is past due, you will receive a letter stating that your account may be heading to collections. 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 may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail.

- **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. Please help us to serve you better by keeping your regularly scheduled appointment.

- **Form Completion Fee.** We require payment for the completion of forms done on your behalf outside of an office visit. These charges are to be paid at the time of service

Mansfield Family Practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the patient expectations and payment policy and agree to abide by its guidelines:

____	________________________
Signature of patient or responsible party	**Date**
____	________________________
Name	**Date of Birth**

Thank you for choosing Mansfield Family Practice for your health care needs. We are pleased to have you as a patient.

MANSFIELD FAMILY PRACTICE

Physician (circle): Dardick Madraswalla Winakor Walker Hughes

Social Security #:	Gender: Male or Female (circle)	
First Name:	Date of Birth:	
Middle Initial:	Marital Status: M S D W O (circle)	
Last Name:	Race/Ethnicity:	
Mailing Address:	☐ I decline to answer Race/Ethnicity	
	E Mail address:	
	Pharmacy:	
Home Phone:	Pharmacy Town:	
Cell Phone:	Emergency Contact Name:	Phone:
Work Phone:	Emergency Contact Relationship:	

INSURANCE INFORMATION (A COPY OF YOUR CARD(S) IS REQUIRED FOR OUR RECORDS)

If you have no insurance, check here ________ (Payment will be required at the time of service)

Primary Insurance:	Secondary Insurance:
Employee/Policy Holder's name:	Employee/Policy Holder's name:
Date of Birth:	Date of Birth:
Policy holder address:	Policy holder address:
Insurance ID #:	Insurance ID #:
Group #:	Group #:
Policy Holder's Employer:	Policy Holder's Employer:

Other family members who belong to the practice:

Name:	**Date of Birth:**	**Name:**	**Date of Birth:**

I request that payment of authorized Medicare & Insurance benefits be made on my behalf to my Physician or covering provider at Mansfield Family Practice, LLC. I confirm that all of the information I have entered is accurate and accept the responsibility of payment for services rendered that are not covered by my insurance plan.

Patient/Guardian Signature Guarantor Relationship Date

MANSFIELD
F·A·M·I·L·Y
PRACTICE
A LIMITED LIABILITY COMPANY
34 PROFESSIONAL PARK ROAD
STORRS, CONNECTICUT 06268
TEL: (VOICE) 860/487-0002
(FAX): 860/429-1663

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below.

2. Authorization for release of PHI covering the period of health care (check one)
☐ from (date) ______________ - to (date) ________________ OR
☐ All past, present and future periods.

3. The following information needs a separate consent to be Used or Disclosed. Please indicate your authorization by checking each item.

☐Consent to ☐Refuse Mental health records
☐Consent to ☐Refuse Communicable diseases (including HIV and AIDS)
☐Consent to ☐Refuse Alcohol/drug abuse treatment
☐Consent to ☐Refuse Other (please specify): ____________________

4. In addition to the authorization for release of my PHI described in paragraphs 2 and 3 of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):
Name(s):__________________________________ Relationship(s):____________________
__________________________________ ____________________

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or __________________________ , (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I acknowledge I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

10. I acknowledge I have received and/or reviewed a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact the Practice Administrator.

11. I understand that the PHI disclosed under this authorization may be subject to redisclosure by the recipient

and no longer protected under federal privacy regulations. I also understand that if the PHI that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, Mansfield Family Practice, LLC may not redisclose that information under Connecticut State Law.

I acknowledge that I have carefully reviewed this Authorization and understand its provisions. If you would like to receive a copy of this executed agreement please enclose a self addressed stamped envelope.

_______________________________ _______________________________

Signature Date

____

Print Name

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of 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. Ask us how to do this. • 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 example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

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 the purpose of 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

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- 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.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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.

This Notice of Privacy Practices applies to the following organizations.