Northeast Endocrinology

OFFICE POLICIES

1. **APPOINTMENT TIME:** We ask that our patients arrive on-time for their appointments. To serve all our patients well, patients arriving past their appointment time may be rescheduled. We require you to confirm your appointments by text/portal message, email or by phone to ensure your appointment time.
2. **NO SHOW FEE**: To avoid our $75.00 No Show/Cancellation/Reschedule Fee, we request that you call at least 48 hrs. in advance, so that we may be able to provide more timely care to other patients who could be scheduled.
3. **CHANGE OF INFORMATION**: Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a New Patient Information Form and may not be changed over the telephone.
4. **INSURANCE AUTHORIZATIONS:** Insurance contracts are between the insurance company and the patient. It is the patient's responsibility to know what services are covered by his/her insurance plan. If the insurance information is not provided at the time of service, the patient will be seen on a cash pay basis.
5. **PAYMENTS**: All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of service. We accept cash, checks, Visa and MasterCard.
6. **SELF-PAY**: If the patient has no insurance and/or is a self-payer, they should make payment arrangements before services are rendered.
7. **ACCOUNT COLLECTIONS**: Any delinquent accounts will be forwarded to third party collections; patient will be responsible for any of all collection fees assessed by the collection agency on to the account.
8. **PORTAL MESSAGES:** All patients have the capability to send a portal message to your Dr. or Dr.'s staff. Portal messages will be returned within 48 hours of business.
9. **MEDICATION REFILLS:** You may request a prescription refill by calling your pharmacy and asking them to send us an electronic refill request if necessary. Also, please note, Prescriptions will be refilled within 72 hours of the office receiving the request. No prescriptions will be provided after hours or on weekends.
10. **PATIENT FORMS**: Any request for completion of forms (FMLA, disability, dispositions, etc) must be done in writing utilizing our "Patient Forms" policy. Forms require 10-14 days for completion once associated fees have been paid. Unpaid forms will not be completed.
11. **CODE OF CONDUCT:** Northeast Endocrinology has a no tolerance policy; Code of conduct is to be always adhered by patients. Any violation may result in being terminated from practice.

__________________________________ __________________

Patient Name/Signature Date

Northeast Endocrinology

<u>CANCELLATION / NO-SHOW POLICY</u>

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement a no-show/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

To be respectful of the medical needs of other patients, please be courteous and contact Northeast Endocrinology promptly if you are unable to attend a scheduled appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you contact us at least **48 hours in advance to avoid $75.00 fee.** Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

No-Show Policy:

A "no-show" is someone who misses an appointment without cancelling or rescheduling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show" and **patient will be assessed a $75.00 fee**.

No Show fees are not covered by your insurance. **No show fee is required to be paid prior to scheduling another visit.**

In the event you have three "no-shows"/cancellations, all remaining appointments may be cancelled and may be referred back to your primary care/referring physician for future medical care.

____________________________________ ____________________

Patient Name – Print Date

____

Patient Signature

NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

210.650.3360 (office) • 210.650-3403 (fax)
www.neendocrinology.com

HIPAA Notice of Privacy Practices Acknowledgment

Acknowledgement of Practice's *Notice of Privacy Practices*:

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms. By signing this form, I also freely consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

______________________________ ____________________
Patient Signature Date

If you are signing this on behalf of patient, please complete below:

Patient Relationship: ______________________________

Reason Patient Cannot Sign: ______________________________

Please list below those who we may inform about your general medical condition, diagnosis, treatment, and billing:

(1) Name: ____________________ Phone Number: ____________________

(2) Name: ____________________ Phone Number: ____________________

To view and/or obtain the HIPAA Privacy Policy visit *www.neenndocrinology.com.*

NORTHEAST ENDOCRINOLOGY

HIPAA Notice of Privacy Practices

PLEASE REVIEW CAREFULLY:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS DOES NOT CHANGE THE OPERATIONS OF OUR OFFICE; NORTHEAST ENDOCRINOLOGY ASSOCIATES HAS ALWAYS STRIVED FOR HIGH STANDARDS REGARDING PRIVACY ISSUES. THIS NOTICE IS A FEDERAL REQUIREMENT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).

If you have any questions about this notice, please contact our privacy officer.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected PHI
- Give you this notice of our legal duties and privacy practices regarding PHI about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies Personal Health Information or PHI. Except for the following purposes, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment. We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside the office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Out of Pocket. If you are paying out of pocket for an episode (one or more visits) and you **DO NOT** want a claim filed with your insurance company, you have the right to request that we don't give the treatment or diagnosis for that specific episode to your insurance company.

Health Care Operations. We may use and disclose PHI for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose PHI to contact you and to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose PHI for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any PHI.

SPECIAL SITUATIONS

As Required by Law. We will disclose PHI when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billings services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release PHI to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donations; and transplantation.

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Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. These activities generally include disclosures to prevent or control disease (including vaccination records), injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release PHI if asked by a law enforcement official if the information is: 1.) in response to a court order, subpoena, warrant, summons, or similar process; 2.) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3.) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4.) about a death we believe may be the result of criminal conduct; 5.) about criminal conduct on our premises; and 6.) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose PHI to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI to the correctional institution or law enforcement official. This release would be made if necessary: 1.) for the institution to provide you with health care, 2.) to protect your health and safety or the health and safety of others, or 3.) for the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding PHI we have about you:

Right to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. You have the right to an electronic or hard copy of your record; the most efficient method via our Patient Portal. We may charge a reasonable fee for copying your records up to current state limits.

Right to Amend. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment, and health care operations or for which you provided written authorization.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.neendocrinology.com

Make all requests in writing to the Privacy Officer, Northeast Endocrinology 7323 North Loop 1604 East, suite 601 San Antonio, Texas 78233.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All requests must be made in writing to: Privacy Officer, Northeast Endocrinology Association, 7323 North Loop 1604 east, suite 601 San Antonio Texas 78233. All complaints must be made in writing. You will not be penalized for filing a complaint.

Received by:

____

Patient Name Date

Physician List

Please include Primary Care Physician and Referring Physician

Please identify those MD's that records are to be requested from:

______________________________ ______________________________

______________________________ ______________________________

Medication List

Please take the time to fill out **all** the information

Name:	Dose/Mg:	Directions:

Supplements or Vitamins:

Name:	Dose/Mg:	Directions:

Please list all medications to which you are allergic:

____

____

Patient Name: ______________________________ **Date:** ______________________________

NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

7323 North Loop 1604 East, suite 601 San Antonio, Texas 78233
Ph# (210)650-3360 Fax# (210)650-3403 info@neendocrinology.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Print Name: ______________________________ ____________________
(Please indicate other names used)

Address: ____
City State Zip

Social Security #: ____________________ Date of Birth: ____________________

I authorize Northeast Endocrinology (to) (Please Select): ____release my record ____ receive my record (from):

Practice: ______________________________Provider:____________________

Address:____
City State Zip

Phone:______________________________ Fax:____________________

I authorize Northeast Endocrinology to release health and financial information on my behalf to the following person(s):

____

PLEASE CHECK INFORMATION TO BE RELEASED:

	Complete Health Records		Operative Reports	
	Financial Details		Laboratory Reports	
	Pathology Reports		X-Ray Reports	

COVERING PERIOD: FROM: ____________ **TO:** ____________

Time Limit & Right to Revoke Authorization
Expect to extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility **of Northeast Endocrinology, A Division of Synergy**. Unless revoked, this authorization will expire **365 days** from date of signature.

Drug and/or Alcohol, and/or Psychiatric, and/or STD/HIV/AIDS Records Released
I understand that the requested information may contain reference to or results of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I have received a copy of the protected health information to be used or disclosed. I authorize Northeast Endocrinology to use and disclose the protected health information specified above.

Signature: ______________________________ Date ____________________

Authority of Sign if not patient: ______________________________

Witness: ____________________

Re-disclosure
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.