# FPA Policies

In order to help you clearly understand our policies and services, please read the following statements and sign the bottom indicating you accept these rules:

- I understand there is a fee for missed appointments or appointments not cancelled 24 hours prior. Please notify us as soon as possible if you cannot make your scheduled appointment.
- Full payment is due at the time of service for insurances with which we do not participate or if there is no insurance at the time of service.
- All copays are due when treatment is rendered. A copay $10 copay fee will be applied if payment is not received by first billing cycle.
- I understand there is a $15 fee for returned checks.
- I understand a fee may be assessed for any paperwork or forms completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. It may take 48-72 hours to process.
- I understand that labs, x-rays, and other test results need to be reviewed and it may take 3-4 days to be reviewed by the physician/NP. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via secure patient web portal with results.
- I understand that I can contact my care team through the patient web portal, Follow My Health (FMH), and that it may take 48-72 hours to get a response. The portal is NOT to be used for urgent matter. Contact the office directly at 610-269-1372 for issues that need to be addressed immediately.
- I understand that I have access to FPA clinicians 24/7 and that I should contact the on-call physician with issues outside of scheduled office hours.

Thank you for your cooperation.

Patient Name (please print):_____

Patient Signature:_____

Date of Birth:_____

Date:_____

# OUR FINANCIAL POLICY

Thank you for choosing FPA as your Primary Care Physicians. We are committed to providing you with caring and expert medical care. Please read carefully and in full the following Financial Policy and sign in the appropriate area. We require that all patients review this policy and complete our Information & Insurance registration form prior to seeing the physician.

**Full payment is due at the time of service for insurances with which we are not participating. If you are unable to meet this requirement, prior arrangements must be made with our billing department.**

**All co-pays are due when treatment is rendered.**

**We accept cash, checks, VISA, MC, Discover, and American Express.**

**Cancellation notice of at least 24 hours is required. If your appointment in NOT cancelled 24 hours prior to your appointment, you will incur a cancellation fee.**

**Regarding Insurance:**

***Your insurance policy is a contract between you and your insurance company*.** We are not a party to that contract. It is the patient's responsibility to be aware of your coverage and benefits, this includes knowing which laboratory your insurance require you to use. Because of the growing number of insurance plans it is very difficult to keep up with all the different benefits. Therefore, if you have any questions concerning your coverage, it is your responsibility to call and discuss your concerns with your insurance company's member services. We cannot bill your insurance company unless you provide us with the correct and updated information required. If there is more than one insurance plan in effect for an individual or family, we must be notified of all policies. If a policy terminates or is replaced by a new policy, the office must be informed of the new information and a copy of the new card or enrollment form must be provided. Please be aware that some services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other insurance companies.

**I understand that if my insurance company denies all or part of my claim that I am responsible for my account. Payments are to be made in a timely manner. If you are unable to do so, please contact our billing office to make other arrangements. If you have a balance at the time of service, a payment is expected towards the balance before being seen by a clinician. If no payment is made on your account after 4 billing cycles, your balance will be submitted to a collections agency. Our office can set up payment plans to avoid this action.**

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the terms of the Financial Policy of the office of Family Practice Associates of Exton and Marshallton, P.C.

**X**_____ **Date:**_____

Signature of Patient or Parent of Minor Patient

**X**_____ **Date:**_____

Signature of Co-Responsible Party

# Family Practice Associates of Exton & Marshallton

## Patient Consent for Use and Disclosure of Protected Health Information (PHI)

I hereby give my consent for Family Practice Associates of Exton and Marshallton, P.C. (FPA) to use and disclose PHI about me to carry out treatment, payment and healthcare operations (TPO). FPA's Notice of Privacy Practices provides a more complete description of such use and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. FPA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Office, Dr. Michael A. McGuire at 770 W. Lincoln Highway, Exton, PA 19341.

With this consent, FPA may call home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory and procedure test results among others.

With this consent, FPA may mail to my home or alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, FPA may email to my home or alternate location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request the FPA restrict how it uses or discloses PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it I bound by our agreement.

By signing this form, I am consenting to FPA's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that FPA has already made disclosures in reliance upon my prior consent. If I decline to sign this consent, or later revoke it, FPA may decline to provide treatment to me.

_____

Signature of Patient of Legal Guardian

_____ Date_____

Patient's Name

_____

Print Name of Patient or Legal Guardian

# Addendum to Privacy Practices-1996 HIPAA

*As Required by the New Mega Rule. The Regulations Appear in the January 24, 2013 Federal Register Effective Date of Notice: 9/23/2013*

## RELEASE AUTHORIZATIONS

1. Psychotherapy Notes- Use and Disclosure of your psychotherapy notes. These are the notes of a mental health professional that are kept separate from the record itself. We may not disclose your PHI records in order to treat you or assist others in your treatment. Also we may not disclose PHI to obtain payment from third parties that may be responsible for such costs, such as family members.
2. Fundraising-
    a. Patients can opt-out of getting fundraising communications from the office.
3. Restricting Information Releases
    a. The office may not disclose a patient who pays for a service in full and out of pocket. The patient can request in writing and has to identify what information is restricted and what insurance company is not to receive it.
4. Breach Notification
    a. Our patient will be notified in writing when a breach in their protected information occurs. That means no breach, no matter how minor, has to be reported to the patient and also covered in the office's year end HIPAA report.

If you have any questions regarding this addendum or our health information privacy policies, please contact Dr. Michael McGuire at 610-269-1372.

_____ _____

Signature Date

_____ _____

Print Name of Patient Date

# Family Practice Assocs. of Exton & Marshallton
# Medical Information Release Form
# (HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

**Release of Information**
I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
O Spouse_____
O Child(ren)_____
O Other_____
O Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.
**Messages**
Please call: [ ] my home [ ] my work [ ] my cell
Number:_____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____