Harrisonburg Dermatology Patient Agreement Forms have been revised to accommodate patient care during COVID-19. The following forms are required annually when a patient physically checks into the practice. If you have any questions, please call the office at 540-433-8700

PATIENT NAME:_____ Patient Date of Birth: _____

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICE IS RENDERED, unless our staff has approved payment arrangements in advance. The Practice accepts cash, checks, Visa, Discover, or MasterCard.

Self-pay patients: payment is due at the time of service. Partial payments are not allowed unless approved by authorized staff. Unless approved by authorized staff, a patient may not receive care unless their balance is less than $500 and a payment plan is in place and current. In the event your account becomes delinquent and transferred to a collection agency, care may not be received until the balance is paid in full.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier.
3. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover.
4. Medicare patients please be aware that we are "participating providers." This means that we have signed a contract to accept their fee schedule for reimbursement for services delivered to Medicare patients. Although we are allowed to and do bill Medicare our usual fee schedule, your responsibility for payments to us of "co-payments and deductibles" are limited to the amounts based on the "par-amount" or the fee schedule dictated by Medicare which is the "Allowed amount for participating physicians."

Account in Arrears

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims for certain services is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered (unless specifically excluded by a particular managed care contract). We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account since all accounts over **60 days** are turned over to our **collection** service for payment. If your account is turned over for collection, you will be responsible for all collection service fees, interest, and all legal fees associated with collecting the account, including but not limited to attorney's fees of 33 1/3 % and all court costs. In the event your account becomes delinquent and transferred to a collection agency, care may not be received until the balance is paid in full.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Insurance Notice – Patients with participating insurance: payment for services is due upon receiving the first invoice.

HMO insurance policies may require **authorizations** before being seen. The **patient is responsible** for knowing if a referral is required. If a referral is not received before the appointment, insurance may not pay for the visit and therefore, the financial responsibility falls to the patient.

Insurance Carriers Harrisonburg Dermatology is in-network with:

- Aetna
- Anthem Blue Cross Blue Shield (**NOT contracted with Anthem HealthKeepers**)
- ChampVA
- Humana – Medicare Advantage
- Medicare
- Mennonite Medical Group
- Optima Commercial
- Optima Medicare Advantage
- Piedmont Community Healthcare, Inc.
- Tricare East
- Tricare Prime (referral required)
- United Healthcare Medicare Advantage (Jeanine Wilson, PA-C)
- Virginia Health Network/Medcost

Most Medicare Advantage plans convey with Medicare. It is the responsibility of the patient to know if their insurance conveys with Medicare

Providers are Harrisonburg Dermatology are NOT contracted with Medicaid or any of the Medicaid Commonwealth Coordinated Care Plus (CCC+) programs. Please feel free to ask any questions. The Practice will accept and file to ALL secondary insurance.

Notice of discharge

There may be times when a patient is not meeting standard patient responsibilities set for a successful treatment plan. Though our staff works hard at preventing a patient from being discharged, there may be instances where there is no other choice but to terminate the patient-to-physician relationship. Reasons for discharge include but are limited to:

1. Nonpayment: If your account is continuously delinquent or has to be written off due to bankruptcy.
2. Non-adherence to Treatment or Follow-Up Care: The patient does not or will not follow the treatment plan or repeatedly cancels follow-up or is a no-show.
3. Misconduct: Verbal or physical abuse from the patient and/or a family member. Rude improper language with office personnel exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.

Patient Attestation

I further understand that I may be billed for appointments **not canceled 24 hours** before my scheduled appointment time. For each instance of not keeping an appointment without 24 hours' notice, the **patient will be charged $60** before making another appointment. This $60 charge is non-refundable and will not be applied to any other patient responsibility.

In addition to the above, I understand that I may be charged a reasonable fee for the copying of my medical record for any purpose. I understand that I may also be responsible for the cost of postage if necessary. The Practice will also retain my medical record for six years from the date of my last visit after which The Practice may destroy my record according to VA laws and regulations.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any medical or other information necessary to process my claim. I also authorize payments under my insurance programs to be made directly to The Practice for any services furnished to me. This authorization also permits the release of information by HCFA (its intermediaries or carriers) on any UNASSIGNED Medicare claims to the above. I further permit copies of the authorization to be used in place of the original.

Patient Signature **Date**

HIPAA Form below: I have received a copy of the Notice of Privacy Practices. The Medical Practice has allowed me to ask any questions about this notice and all my questions have been answered. *The form below is the patient copy and does not need to be returned to the office.*

Patient Signature **Date**

HIPAA Notice of Privacy Practices (PATIENT COPY)

Here forth, Harrisonburg Dermatology shall be known as The Practice.

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. If you have any questions about this notice, please contact the Office Manager.

Who Will Follow This Notice: This notice describes our office's practices. We may share information for your care. Our Pledge Regarding Medical Information: We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care you receive at this office to provide you with quality care and to comply with legal requirements. This notice will tell you about how we use and disclose your medical information. We also describe your rights and the obligations we have regarding the use and disclosure of medical information. We are required by law to make sure that medical information that identifies you is kept private; give you this notice of our privacy practices concerning your medical information, and follow the terms of the current notice.

How We May Use and Disclose Medical Information About You: For Treatment. We may use information about you to provide you with medical treatment. We may disclose medical information about you to office staff and others involved in your care. For Payment. We may use and disclose information about you for insurance and payment services. For Health Care Operations. We may use and disclose information about you for practice operations to make sure that you receive quality care and for learning purposes. Appointment Reminders. We may use and disclose information to contact you about appointments. Phone Messages. We may call and leave messages with whoever answers the phone at your house or on your answering machine unless directed otherwise. Treatment Alternatives. We may use and disclose information to tell you about treatment options. Health-Related Benefits and Services. We may tell you about health-related benefits or services. Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in or helps pay for your medical care. We may disclose medical information about you to assist in a disaster relief effort. As Required By Law. We will disclose information about you when required to do so by law. To Avert a Serious Threat to Health or Safety. We may use and disclose information about you to prevent a serious threat to your health and safety, the public, or to another person.

Special Situations: Organ and Tissue Donation. If you are an organ donor, we may release information to organ banks.

Military and Veterans. We may release information about military personnel as required. Workers' Compensation. We may release information about you for workers' compensation. Public Health Risks. We may disclose information about you for public health activities. Health Oversight Activities. We may disclose information to a health oversight agency. Lawsuits and Disputes. We may disclose information about you in response to a court or administrative order, a subpoena, discovery request, or another lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.

Law Enforcement. We may release information to a law enforcement official as required by law. Coroners, Medical Examiners, and Funeral Directors. We may release information to a coroner, medical examiner, or funeral director as necessary. National Security and Intelligence Activities and Protective Services for the President. We may release information about you to authorized federal officials for national security activities. Inmates. We may release information about inmates to a correctional institution or law enforcement.

You have the following rights regarding medical information we maintain about you: Right to Inspect and Copy. You have the right to inspect and copy your medical information. This includes medical and billing records but does not include psychotherapy notes. You must submit your request in writing to the Office Manager. We may charge a fee for the costs of copying. We may deny your request to inspect and copy. You may request that the denial be reviewed. Another neutral health care professional, not the person who denied your request, will review your request and the denial. We will comply with the outcome of the review.

Right to Amend. If you feel that your information is incorrect or incomplete, you may ask us to amend the information. You may request an amendment as long as the office has this information. Your request must include the reason, be made in writing, and submitted to the Office Manager. We may deny your request if you ask us to amend information not created by us unless the person that created the information is no longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy, or is accurate and complete. Right to an Accounting of Disclosures. You have the right to request a list of the accounting of disclosures we made of your medical information. You must submit your request in writing to the Office Manager. Your request must state a period, not longer than six years, and indicate whether you want the list on paper or electronic. Your first requested list within a year is free.

Right to Request Restrictions. You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment, and health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed in an emergency. You must make your request in writing to the Office Manager. You must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or location. You must make your request in writing to the Office Manager. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We have the right to deny your request. 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. To obtain a paper copy of this notice, ask the receptionist.

Changes to this Notice: We reserve the right to change this notice and make the revised notice effective for information we already have about you as well as any future information. We will post a copy of the current notice in the office. Each time you register at the office we will offer you a copy of the current notice.

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. To file a complaint with the office, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information: Other uses and disclosures of information not covered by this notice will be made only with your written permission. You may revoke that permission in writing at any time. Understand that we are unable to take back any permitted disclosures and that we are required to retain records of your care.

By signing this consent, you acknowledge that this Medical Practice has informed you of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the Federal law concerning medical privacy, requires this notice.