EPIDA FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office financial policy allows for a good flow of communication and enables us to achieve our goal.

Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please check in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and your consent to us to bill them on your behalf.
2. According to your insurance plan, you are responsible for any and all copayments, deductibles, and coinsurances.
3. We do submit to secondary insurance plans.
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists. Please provide our office with your primary care physician's contact information.
5. **If you do not have insurance, payment for an office visit is to be paid at the time of the visit.**
6. **Co-payments are due at the time of service.**
7. Patient balances are billed upon receipt of your insurance plan's explanation of benefits. Your remittance is due within **10 business days** of your receipt of your bill.
8. If previous arrangements have not been made with our office, any account balance that is outstanding for greater than 28 days will be deemed past due. Any balance over 60 days may be forwarded to a collection agency.
9. A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees.
10. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
11. **If you miss an appointment or do not contact us with at least 24 hour prior notice, we will consider this a missed appointment and a $35 no-show fee will be assessed to you. This applies to late cancellations and no-shows.**

I have read and understood this financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name:_____Responsible Party's Name:_____

Responsible Party's Signature:_____Date:_____

Relationship to Patient:_____

****PLEASE NOTE: If a patient's referral is not received the day before his/her appointment, the patient will not be seen and will be rescheduled.****

EPIDA

Eastern Pennsylvania Infectious Diseases Associates, LLC

PATIENT DATA SHEET

(Please Print)

Today's Date: _____ Primary Care Physician: _____

Chose clinic because/Referred to clinic by (please check one box):

☐ Doctor Name: _____

☐ Insurance Plan: _____

☐ Hospital: _____
☐ Family
☐ Friend
☐ Close to home/work
☐ Yellow Pages
☐ Other: _____

PATIENT INFORMATION

Patient's last name: First: Middle: Social security #: Birth date: - - Sex: ☐ M ☐ F

Street address:

City: State: Zip code:

Home phone # ( )

Employer phone # ( )

Cell phone # ( )

Marital status (Please check one)
☐ Married ☐ Divorced ☐Single ☐Widowed

Are you a student?

☐ No ☐ Yes Part-time: _____ Full-time: _____

Are you a veteran?

☐ Yes ☐ No

Do you smoke?

☐ Yes ☐ No

Employer: Occupation:

Employment status:

☐Full Time ☐Part Time ☐Retired ☐Unemployed

Employer's street address : City: State: Zip code:

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to patient: Home phone #: ( ) Work or cell phone #: ( )

INSURANCE INFORMATION

(Please give your photo ID and insurance cards to the receptionist.)

Name of primary insurance: Subscriber's name: Subscriber's date of birth: / / Subscriber's social security number:

Policy/ID number: Group number:

Patient's relationship to subscriber:

❑ Self ❑ Spouse ❑ Child ❑ Other

Subscriber's address (if different from patient's):

Name of secondary insurance (if applicable): Subscriber's name: Subscriber's date of birth: / / Subscriber's social security number:

Policy/ID number: Group number:

Patient's relationship to subscriber:

❑ Self ❑ Spouse ❑ Child ❑ Other

Subscriber's address (if different from patient's):

Tertiary insurance: Subscriber's name: Subscriber's date of birth: / / Subscriber's social security number:

Policy/ID number: Group number:

Patient's relationship to subscriber:

❑ Self ❑ Spouse ❑ Child ❑ Other

Subscriber's address (if different from patient's):

Release of Information

Your medical records may be sent to another medical facility to ensure continuity of care. Other than releasing this information to any medical provider's necessary for treatment, payment, or operations, it is the office policy of EPIDA and staff not to release medical and/or confidential information to anyone other than the patient and authorized third parties. If you give us permission to leave a message, the message for routine care will be to call our office. In case of an emergent situation, the message will be to call our office in regards to an urgent matter.

I give permission to EPIDA and/or their staff to leave a message for me without divulging medical information pertaining to my care, and will assume responsibility to notify EPIDA if any of the above information changes.

Do you have voicemail? ☐ Yes ☐ No

Patient to read and then sign:

The information included on this form is true to the best of my knowledge. The signature below authorizes the release of my medical information required by my insurance carrier(s) to process my claims and authorizes my insurance benefits to be paid directly to EPIDA.

I understand that I am ultimately responsible for any balance(s) due for any professional service rendered. This includes, but is not limited to, co-insurance, co-payments, deductibles, non-covered services, etc.

☐ I have read and understand the information on this form. I have no further questions about the information on this form.

Patient/Guardian (if patient under 18 years of age) Printed Name: _____

Patient /Guardian Signature: _____ Date: _____

Patient Name: _____

CONFIDENTIAL SOCIAL HISTORY SHEET

Please check the boxes that pertain to you.

TOBACCO

- o Current every day smoker
- o Current some day smoker
- o Former smoker
- o Heavy tobacco smoker
- o Light tobacco smoker
- o Never smoker
- o Smoker, current status unknown
- o Unknown if ever smoked

ALCOHOL

- o Do not drink
- o Drink daily
- o Frequently drink
- o History of alcoholism
- o Occasional drink

EASTERN PENNSYLVANIA INFECTIOUS DISEASE ASSOCIATES, LLC.
MEDICATION RECORD

Patient Name: ______________________________ DOB: ____________________

Pharmacy: ______________________________ Flu Shot: Yes_____ No_____
Allergies: ______________________________ Date: ____________________

Medication - Dose - Frequency	**Indication**	**start date**	**refill dates**			**stop date**

EASTERN PENNSYLVANIA INFECTIOUS DISEASE ASSOCIATES, LLC

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE INFORMATION

I,_____, hereby authorize EPIDA to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, EPIDA can refuse to treat me.

I have been informed that EPIDA has prepared a notice ("Notice") which more full describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying EPIDA, in writing, but if I revoke my consent, such revocation will not affect any actions EPIDA took before receiving my revocation.

I understand that EPIDA has reserved the right to change his/her privacy practices and that I can obtain such changes upon request.

I understand that I have the right to request that EPIDA restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or healthcare operations. I understand that EPIDA does not have to agree to such restrictions, but that once such restrictions are agreed to, EPIDA must adhere to such restrictions.

_____ _____

Patient's signature Date

_____ _____

Patient/Guardian signature(if patient is under 18 years of age) Date

EASTERN PA INFECTIOUS DISEASE ASSOCIATES

IMPORTANT: 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.

EASTERN PA INFECTIOUS DISEASE ASSOCIATES is required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know, how EASTERN PA INFECTIOUS DISEASE ASSOCIATES is permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT THE HIPAA Privacy Officer Liaison and someone will contact you.

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.

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how EASTERN PA INFECTIOUS DISEASE ASSOCIATES is permitted to use and disclose Protected Health Information (PHI) about you.

Uses and Disclosures of PHI:

EASTERN PA INFECTIOUS DISEASE ASSOCIATES may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization.

EASTERN PA INFECTIOUS DISEASE ASSOCIATES is permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For EASTERN PA INFECTIOUS DISEASE ASSOCIATES 's use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew; If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

EASTERN PA INFECTIOUS DISEASE ASSOCIATES

HIPAA Privacy Officer Liaison
649 N. Lewis Rd., Ste. 220
Royersford, Pa. 19468

Effective Date of the Notice:
04/21/2021

_____

Signature of Patient

_____

Printed Name of Patient

• To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law;
• For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
• For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
• For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
• For military, national defense and security and other special government functions;
• To avert a serious threat to the health and safety of a person or the public at large;
• For workers' compensation purposes, and in compliance with workers' compensation laws;
• To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
• If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
• For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;
• We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it).

You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.

Patient Rights: As a patient, you have a number of rights with respect to the protection of your PHI, including:

The right to access, copy or inspect your PHI.

This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed at the end of this Notice.

The right to amend your PHI. The right to request amending your PHI.

You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request will be denied. If you wish to request that we amend the medical information that we have about you, you should contact in writing the privacy officer listed at the end of this Notice.

The right to request an accounting of our use and disclosure of your PHI. You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment.

EASTERN PA INFECTIOUS DISEASE ASSOCIATES is not required to agree to any restrictions you request, but any restrictions agreed to by EASTERN PA INFECTIOUS DISEASE ASSOCIATES are binding on EASTERN PA INFECTIOUS DISEASE ASSOCIATES.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: EASTERN PA INFECTIOUS DISEASE ASSOCIATES reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed at the end of this Notice. Individuals will not be retaliated against for filing a complaint.