Houston Rheumatology & Arthritis Specialists
Dr. Kiran Farheen M.D.

DISCLOSURES AND WAIVERS

FINANCIAL POLICY

In order to provide a reasonable quality of healthcare it is very important for a practice to stay financially viable. Payment is due at the time of service unless arrangements have been made in advance. We accept cash, Visa, MasterCard, Discover and American Express. We reserve the right to accept checks for our established patients.

Upon your arrival, your benefits will be explained to you, to the best of our understanding and you will be asked to authorize a credit card on file to authorize payments, above and beyond your co-pay to cover the remaining deductible or co-insurance amount you may owe. We will securely store your credit card information per PCI guidelines. We will always try to work with you and your insurance. We will not charge anything to your card until we have an exact balance returned to us from your insurance company.

_____ Initials - I authorize Houston Rheumatology & Arthritis Specialists to store my credit card in a secure electronic format that is PCI-DSS compliant.
I understand an email with a statement will be sent to the email provided. The credit card will be charged WITHIN A WEEK of the email; if no email address is provided, a paper statement will be mailed, and the credit card will be charged a week later.

_____ Initials - I understand the services rendered may not be covered by my health plan. If the insurance plan determines a service to be "not covered" I will be responsible for the complete charges. If it is later determined that my coverage was not active on the day of the service, I will be responsible for the charges.
I confirm the following is the correct email address:
_____

Your health plan is a contract between you and your insurance company. Health plans vary widely as far as benefits are concerned and in some instances your responsibility may not be evident until we get a response from the insurance company. You will be responsible for co-pay, co-insurance, and deductible and uncovered charges, if they apply to you. If you are unable to pay, please call the office for setting up a payment plan or an alternate arrangement. No response after repeated attempts to contact you will result in your case being referred to a collection agency.

_____ Initials - A charge of $25 will apply for all returned checks. I understand and agree that such terms may be amended by the office from time to time.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipts if the initial statement.
- Payment is in full due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be referred to a professional collection agency for further collection activity. You will be responsible to pay all collection cost incurred, including attorney's fees and court cost if applicable.

- If you are unable to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $30.00 to your original balance. In addition, we may seek additional legal remedies provided to us under Texas law.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits payable for serviced provided by Kiran Farheen MD PLLC, including Medicare, private insurance and any other health plans to Kiran Farheen MD PLLC. I further authorize a release of any medical information necessary to process the claim and payment of benefits. A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until I revoke in writing.

Signature: _____Print Name_____

APPOINTMENT POLICY

Our goal is to provide quality individualized medical care in a timely manner. "No shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.
Please note that the office attempts to call, text or email you to confirm your appointment with us one to two days prior to your visit.

No Show Policy
A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the medical record as a "no-show". Emergency cancellations are accepted for major illness, illness of a family member or death in the family.
After three no show appointments, the office reserves the right to discharge a patient from the practice.

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Initials - Missed appointment: There is a $25.00 charge for no shows for follow up office visits and $50.00 for a missed new patient appointment. The charge is not billable to insurance you will be responsible for payment out of pocket.

Cancellation of an Appointment
In order to be respectful of the medical needs of other patients, please be courteous and call the office at 346-257-4299 promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.
Late Cancellations: A late cancellation is when a patient fails to cancel their scheduled appointment with a 24-hour advance notice. Late cancellations may be charged as no shows.

TO CANCEL APPOINTMENTS, PLEASE CALL 346-257-4299 BETWEEN 8AM – 5PM.

MEDICATION REFILL POLICY:

I understand that should I need any refills on my medications, they should be requested during my appointment with the doctor. I understand that if I make any requests outside of this time, I must allow 3-5 business days for my prescriptions to be filled. I take responsibility to call the office in the appropriate time frame for my medications to be refilled before I run out. If there is a change in my pharmacy information, I take responsibility to give the office updated information.

Opioids and controlled substances will not be filled outside of regular business hours and physician must have seen the physician in the past 3 months for refills on these medications. Additionally, I am aware that based on my insurance and prescription benefits, a 90-day supply of these medications may not be permitted. I am responsible to inquire and be aware of my insurance policy on this subject.

Signature: _____Print Name_____

Request for Medical Records and any Additional Paperwork

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Initials- I understand and agree to pay a $25 fee for requesting a hard copy of my medical records and for any other additional paperwork that I would like my doctor to fill out. I understand that it can take up to 72 hours for my medical records to be processed and up to 2 weeks for other forms to be filled out.

Acknowledgement of Review of Notice of Privacy Practices

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Initials - I have reviewed this office's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Initials - I authorize the following person/people full access to my medical records and allow them to receive medical phone messages from the clinic. I also allow the following individuals to speak with Dr. Kiran Farheen directly regarding all my medical information, testing results, and medical decision making:

_____ _____ _____

(I realize that my not electing this, the doctor's office cannot leave a message with any one in my home regarding results or further care.)

DECLARATION

I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement than the rendition of services. All of my questions have been fully answered.

_____ _____

PATIENT SIGNATURE **Date**

HIPAA Notice of Privacy Practice

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOUSED AMD HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (IPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care service to you, to pay your health care bills, to support the operation of the physicians practice and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities. Employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected heath information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicated your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of appointments. We may use or disclose your protected health information in the following situations without your authorizations.

These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity, National Security, Workers Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Security of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.
Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in authorization.

Following is a statement if your rights with respect to your protected health information: You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Acknowledgement of Receipt of Notice

I hereby acknowledge that a copy of this medical practices Notice of Privacy Practices with effective date of January 2, 2019 was posted and available to read in the reception area

Signed: _____ Date: _____

Print name: _____ Telephone:_____

If not signed by the patient, please indicate your relationship to the patient:

□ Parent or guardian of minor a patient

□ Guardian of conservator of an incompetent patient

□ Beneficiary of personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

□ Signed form received by: _____

□ Acknowledgment refused:

Efforts to obtain:

_____
_____

Reason for
refusal:_____
_____
_____