F Kelly Cunningham MD, PA
3003 Bee Cave Rd., Suite 200 Austin, TX 78746
Phone: 512-410-0767 Fax: 512-649-7402

Patient Rights & Responsibilities

As a patient of F Kelly Cunningham MD, PA, you have the right:

- To be treated with courtesy and respect.
- To have your privacy protected and to receive our Notice of Privacy Practices.
- To have your questions answered promptly.
- To know the name, role and qualifications of your caregiver.
- To know what services are available, including translators.
- To know what rules apply to you.
- To have information about your diagnosis, choices, risks and benefits of treatment so you can assist in developing your plan of care, including the management of pain.
- To refuse treatment except as otherwise provided by law.
- To be given, on request, information and counseling on available financial resources.
- To know, on request and before treatment, whether Medicare assignment is accepted.
- To receive, on request and prior to treatment, a reasonable estimate of charges for medical care and, on request, an itemized bill with charges explained.
- To receive medical treatment regardless of race, national origin, religion, physical handicaps, or sources of payment and to expect appropriate management of pain.
- To receive treatment for any emergency medical condition that may get worse if not treated.
- To know if medical treatment is for research and to either consent or refuse.
- To have the right to make Advance Directives.
- To be free from restraint and seclusion which are not medically necessary.
- To the confidentiality of your medical record and the right to access information from it.
- To have a family member or representative and your physician notified promptly of admission to the hospital.

As a patient at Kelly Cunningham MD, PA, you are responsible:

- To give your health care provider correct and complete information about your present medical condition, past illnesses, hospitalizations, medications, including over-the-counter drugs/herbal supplements, and other health matters.
- To report changes in your condition and report perceived safety concerns in your care.
- To tell your health care provider if you understand the plan of treatment and what is expected of you, including pain relief options and ask questions if you do not understand.
- To follow the treatment plan recommended by your health care provider.
- To keep appointments or notify the health care provider or facility if you cannot.
- To accept responsibility for your actions if you refuse treatment or do not follow the health care provider's instructions.
- To meet your health care financial obligations promptly.
- To follow rules and regulations on patient care.
- To be considerate of the hospital's personnel and property.

I have read and understand my rights and responsibilities as stated within this form.

_____
Patient's Printed Name

_____ _____
Patient (or Responsible Party) Signature Date

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Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How May I Pay?
We accept payment by cash, check, VISA, Mastercard and Discover.

What Is My Financial Responsibility for Services?
Your financial responsibility depends on a variety of factors, explained below.

Office Visits and Surgeries

If You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you & File an insurance claim on your behalf.
HMO with which we are not contracted.	Payment in full for office visits, x-ray, injections, and other charges at the time of office visit.	Provide the necessary information for you to complete and file your claim directly with the insurance company.
Point of Service Plan or Out of Network PPO	Payment of the patient responsibility—deductible, copay, non-covered services—at the time of the visit.	Call your insurance company ahead of time to determine out of network benefits, copays, deductibles, and non-covered services & File an insurance claim on your behalf.
Medicare	Any services not covered by Medicare are requested at the time of the visit. If you have Regular Medicare as primary, and also have secondary insurance or Medigap: No payment is necessary at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
Office Appointment No Show	Letting us know 24 hours in advance if you can't make an office appointment. Paying a $35 administrative fee if you aren't able to cancel 24 hours in advance.	Confirm your appointment the 1-2 days in advance of your appointment.
Procedure/Surgery Scheduling	We have a $100 deposit which is applicable to your deductible or co-insurance. It is non-refundable if you reschedule (more than three times) or cancel less than 48 hours in advance.	Our staff will handle all your insurance authorization and questions. They will also coordinate with the surgery center.
No Insurance	Payment in full at the time of the visit.	Work with you to settle your account. Please ask to speak with our staff if you need assistance.

- *I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility.*
- I authorize my insurance benefits be paid directly to ***Kelly Cunningham MD PA***.
- *I authorize **Kelly Cunningham MD PA** to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.*

_____ _____ _____

Date **Signature** **Printed Name**

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Consent for Treatment

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments.
- Administration of intra-articular and/or extra-articular injections with medication including but not limited to steroid, anesthetic, gadolinium, iodine, normal saline, PRP, MSC, and placental MSC, with or without image guidance/oral sedation, as deemed medically necessary by the physician or their assigned designees.
- Performance of venipuncture for treatments as deemed medically necessary by the physician or their assigned designees.
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures, x-rays, and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature **Date**

_____

Patient's Printed Name

_____

Witness

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Physician Ownership Disclosure Form
Kelly Cunningham MD, PA

During the course of your physician/patient relationship with Dr. Kelly Cunningham's office, he may refer you to the following facilities:

- MoPac Imaging – 3742 Far West Blvd., Ste. 109 Austin, Texas 78731
  - Diagnostic Imaging: MRI, CT Scan, Arthography
- Stonegate Surgery Center – 2501 W.William Cannon Dr., Ste. 201 Austin, TX 78745
  - Ambulatory Surgical Center
- Fortis Labs, LLC – 17174 McKinney Ave., Dallas, TX 75202

In connection with any referral to these facilities, you are hereby advised that Dr. Kelly Cunningham may have an investment interest in these facilities, and is a paid consultant for Celling Biologics, Austin, TX.

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than the facilities listed above. You will not be treated differently by your physician or these facilities if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact Bryan Schwiening at 512-423-1877. By signing below, you acknowledge that should you be referred to these facilities, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility. Lastly, you further acknowledge by signing below that you signed Physician Ownership Disclosure Form prior to Dr. Kelly Cunningham's referral of you to the Hospital.

Date: _____, 20___

Signature of Patient: _____

Printed Name of Patient: _____

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DISCLOSURE

To provide efficient quality service to the patient, we require that you carefully review and sign the following agreement. (Pursuant to TWCC Rule 120.1 FIGURES 1 & 120.2)

If you are seeking care at our office for an injury/condition due to work, please note that we are required by the Texas Workers' Compensation Commission laws to handle your claim with your employer's Workers' Compensation Insurance Carrier. After you have reviewed the provided information, please check the most applicable statement.

☐ I certify that my injury/condition **IS w**ork related.
Should your injury become fully adjudicated not to be compensable as defined by the Division of Worker's Compensation or the insurance carrier is relieved under 408.024 of the Texas Worker's Compensation Act, or your claim is denied, you will assume all financial responsibility for the billing of your injury/condition; at which time, you may provide your private health insurance information.

☐ I certify that my injury/condition **IS NOT** work related.

AGREEMENT

As a patient of Kelly Cunningham M.D., with a work related injury/condition, it is your responsibility to inform the facility immediately of the following.

- You must provide us with your employer's information:
  - Name of the Company
  - Name of the contact person
  - Phone Number
- You must provide us with your employer's Workers' Compensation Insurance Carrier Information:
  - Name of the carrier
  - Name of contact person
  - Claim #
  - Phone number
- You must inform this facility if you have had any of the following:
  - Designated Doctor Evaluation
  - Required Medical Evaluation
  - Impairment Ratings
- You must immediately notify us if your claim is disputed, denied, or if you receive a Notice of Refusal to Pay Benefits, more commonly referred to as a DWC 021 and/or PLN-11

Failure to disclose any of the above information in a timely manner will cause you (the patient) to become financially responsible for all services rendered. Should you have questions regarding the disclosure, please ask to speak to a Worker's Compensation Representative.

ACKNOWLEDGEMENT

Signature:_____Date:_____

Patient Name:_____

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Acknowledgement of Receipt of Privacy Notice

I understand Kelly Cunningham MD PA, reserves the right to change their Notice of Privacy Practices. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

_____ _____

Patient's Printed Name Date of Birth

_____ _____

Patient/Legal Representative Signature Date

_____

Relationship to Patient

_____ _____

Witness Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Kelly Cunningham MD PA to share my protected health information with:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I wish to be contacted in the following manner:
☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Ok to leave message with detailed information?
☐ Yes ☐ No

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NOTICE OF PRIVACY PRACTICES

Effective January 1, 2017

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.

Uses and Disclosures

Treatment
Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician or other specialists share your medical information with us. Also, we may provide your primary care physician and other specialists with information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment
Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations
Your health information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement
Your health information may be disclosed to law enforcement agencies to support government Audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting
Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

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Additional Uses of Information

Appointment Reminders
Your health information will be used by our staff to send you appointment reminders via the telephone, electronic mail and/or the US mail.

Information about treatments
Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Communication
Communication to the medical staff via the austinorthobio.com email is a non-secure and non-encrypted email service. A secure, encrypted email communication is available upon request. The most secure form of communication to our office is via fax number 512-649-7402. Phone communication to our medical staff is utilized using a voicemail system, RingCentral, and voicemails are sent directly to the austinorthobio.com email. These voicemails are only used by the medical staff to communicate with patients for their medical treatment.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Practice Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

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Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. You will be charged a fee as limited by The Texas State Board of Medical Examiners for the copy of your records.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can contact the Privacy Officer at the address shown below. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address shown below. You will not be penalized or otherwise retaliated against for filing a complaint. You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
F Kelly Cunningham MD, PA
12401 Hymeadow Drive, Suite 1-B
Austin, TX 78750
512-410-0767