Fort Bend Rheumatology Associates

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

FBRA Patient Policies

Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Assignment of Benefits Policy

I have reviewed the FBRA Assignment of Benefits Policy, which authorizes my insurance carrier(s) to issue payment directly to the office of my rendering provider.

Financial Policy

I have reviewed the Financial Policy for Fort Bend Rheumatology Associates, which explains that payment or an estimation of payment is due prior to services being rendered. I understand that if additional payment, if any, will be collected after services are rendered.

No Show Policy

I understand that if I do not show up for my appointment or do not give 24 hours advanced notice, a charge of $50 will be added to my account. I understand that I will not be seen by the physician until the no show fee has been paid in full.

Furthermore, I acknowledge that I have a right to receive a copy of all the policies for which I am signing.

Signature of Patient or Personal Representative: X_____

Name of Patient or Personal Representative: X_____

Description of Personal Representative's Authority: X_____

Initial: _____
Date: _____

Fort Bend Rheumatology Associates

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

Notice of Privacy Practices
Fort Bend Rheumatology Associates

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the office of Fort Bend Rheumatology Associates.

A. Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people or recalls of products they may be using.

Initial: _____
Date: _____

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports or child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information during judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena.
- The information pertains to a victim of crime, and you are incapacitated.
- The information pertains to a person who has died under circumstances that may be related to criminal conduct.
- The information is about a victim of crime, and we are unable to obtain the person's agreement.
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation

We may disclose your medical information as required by workers' compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purposes of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Initial: _____
Date: _____

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

Required by Law

We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e, on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, if we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days or your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.

Initial: _____
Date: _____

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days or your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first account of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request before any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact our office at the number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government. You may contact our office at 281-980-1742 for any questions or concerns you have.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Information for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:
Fort Bend Rheumatology Associates
7616 Branford Place, Suite 320 Sugar Land, TX 77479
P: 281-980-1742 F: 281-980-1754

Initial: _____
Date: _____

Fort Bend Rheumatology Associates

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and my other health/medical plan, to issue insurance payment directly to Fort Bend Rheumatology Associates, PLLC for medical services rendered to myself and or my dependents regardless of my insurance benefits, if any. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release of Information

I hereby authorize Fort Bend Rheumatology Associates to:

1. Release any information necessary to my insurance carriers regarding my illness and treatments
2. Process insurance claims generated in the course of examinations or treatment
3. Allow a photocopy of this assignment (including my signature) to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Fort Bend Rheumatology Associates on behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment of benefits is to be considered as valid as the original.

Initial: _____
Date: _____

Fort Bend Rheumatology Associates

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

Financial Policy

Thank you for choosing Fort Bend Rheumatology Associates to provide your medical care. We are committed to providing quality care at a fair monetary rate to our patients. Our professional services are rendered to you, not your insurance company; therefore, payment for treatment is your responsibility.

Please notify us of any change in your insurance, address, place of employment, phone number, etc. when you arrive and before you see your physician or have any testing. Failure to notify us of these changes will result in you being responsible for the bill. It is your responsibility to know and understand your insurance.

About our Fees
We believe our fees are reasonable for our practice area. Our fees are determined by analyzing charge information provided by contracted insurance networks at both the regional and national levels. The provider determines the level of service that is billed for each encounter. This determination is made based on several factors including the number of problems the patient is being seen for, the severity of the patient's condition, the time spent face to face with the patient discussing their condition, as well as the time spent analyzing the patient's clinical information. Each of these factors contributes to the level of care and ultimately the charge associated with each patient's visit.

Payment for Services
Fort Bend Rheumatology Associates will file charges for office services and accept the contractually agreed-upon amounts. The patient is responsible for the co-payment, co-insurance, and deductible, if any. Please remember these amounts are dictated by specific insurance plans. Discounts cannot be given on co-payments, co-insurance, or deductible due to our contractual agreements with the insurance companies. **If you have a policy that requires a referral or authorization such as an HMO you are responsible to obtain a valid referral prior to your visit, failure to do so will become patient's responsibility for any amount owed.**

Co-payments are collected prior to office visits. Appointments will be rescheduled if co-payment is not paid.

Any insurance claims that have been denied will become the patient's responsibility.

Self-pay (no-insurance) fees are payable in full at the time of service. We will collect a deposit at check-in and then the remaining balance, if any, will be collected at the check-out window. A "prompt pay" discount of 20% of office visit charges will be given when fees are paid in full at the time of service.

You will be asked to pay a minimum of 50 % from any outstanding balance before we provide any further services plus any amount owed at the time of service for that day. Please review your explanation of benefits received from your insurance carrier, which will clarify any balance due from you. Accounts with balances may be required to make payment prior to scheduling appointments or refilling prescriptions.

Payment Methods
Cash, personal check, debit card, Visa, Mastercard, American Express, and Discover are accepted. Credit card payments may be made in person or by phone. Personal checks may NOT be post-dated. Any returned check from the bank for insufficient funds will result in the patient's account being assessed a $25.00 fee per check returned. FBRA will not accept checks from patients who have previously had two returned checks.

Initial: _____
Date: _____

Fort Bend Rheumatology Associates

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

Referral Policy:

Fort Bend Rheumatology Associates is requiring all policies that require a referral such as HMO policies to be sent to us one day prior to any services. It is the patient's responsibility to obtain a valid referral from a primary care physician prior to any services here at Fort Bend Rheumatology Associates, we will not be responsible for contacting your primary care physician to obtain any referrals. **Without a referral your insurance will not cover the cost of your care therefore any amount owed will become patient's responsibility.** If you do not understand your insurance policies terms and conditions on referrals, please contact your insurance provider. This policy will go into effect on July 1st, 2021, we thank you for understanding.

Initial: _____
Date: _____

Fort Bend Rheumatology Associates

J. Edward Hernandez, M.D., F.A.C.R.
Ryan Valicek, M.D.
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
(281) 980-1742
(281) 980-1754 fax
www.fortbendrheumatology.com

No Show Fee

Due to high patient demand and the limited availability of appointments, FBRA has instituted a **"No Show and Late Cancellation Fee"** policy that will result in a $50 fee if you cancel your appointment with less than 24 hours' notice or do not show up for your appointment. **Patients who cancel their appointments at least 24 hours in advance will not be charged a fee.** Timely cancellation will allow this appointment time to be offered to another patient. **This policy will go into effect on January 1, 2020.** Thank you for understanding.

Initial: _____
Date: _____