New Deductible Policy
10/20/17

As of 10/20/17, our practice has implemented a new policy regarding collections of patient insurance deductibles.

We have initiated a policy to collect unmet deductibles on all office procedures up front. All of these unmet deductibles will be collected on or before the time of service. This is in addition to your copay, which is also collected at the time of service.

The definition of procedure includes any office procedure such as a colposcopy, colposcopy with biopsy, biopsy of any tissue, removal of foreign body, hysteroscopy, and/or any other procedure performed in the office by our providers.

We will contact your insurance company to obtain your deductible amounts and contact you prior to your visit to inform you of your amount due.

The amount you are being asked to pay may not be exact, as there may be outstanding claims from another provider that your insurance has not applied to your deductible yet, and/or you may have an additional or different procedure in the office than what you may have been scheduled for. For an example: you may be scheduled for a colposcopy, but when the provider exams you finds something and decides it needs to be biopsied. She would then biopsy it at that time. Therefore, the price of the procedure is then different than what was expected because an additional procedure was performed. In these instances, you would be responsible for the remaining costs of the procedure, in addition to what you initially paid and will receive a bill for that.

All patients are responsible for their copays, deductible, and coinsurance amounts. Please be aware of your insurance policy and coverage as it is ultimately the patient's responsibility.

There are absolutely no exceptions to this policy.

Patient's signature: _____ Date: _____

Ultrasound Office Policy

Once you have agreed to schedule an ultrasound appointment with the office, you have agreed to a have a transvaginal and/or pelvic ultrasound in our office with our ultrasound technician.

If you need to cancel or reschedule your appointment, you must do so no later than the day before the scheduled appointment.

A fee of $50 will apply to all patients who do not show up for their ultrasound, and for those who reschedule or cancel the appointment on the same day of service. This fee is non-negotiable.

The ultrasound schedules fill up quickly, and to be able to provide a service to all our patients, we have to be able to provide them with openings in our schedules. If a patient does not appear for her appointment, or cancels and/or reschedules on the same day, we are left with openings in the schedule that we could have offered to another patient.

I understand the policy stated above:

Name: _____

Signature: _____

Date: _____

Patient Authorization for Use and Disclosure of Protected Health Information to Third Parties

Florida Gynecologic Oncology and Robotic Surgery

Section must be completed for all authorizations

I hereby authorize the use of disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Persons/Organizations Receiving Information

NAME	RELASHIONSHIP & PHONE

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/____/____. **Initial_____**

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation. **Initial_____**

_____ _____

Signature of patient or representative Date

(Form must be completed before signing)

Printed name of patient's representative: _____

Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Patient HIPAA Authorization
PHI Release

Under the HIPAA law, Healthcare providers are able to leave limited or detailed messages on a phone voicemail, depending upon the patient's preference. Please indicate you preference below.

☐ I **do not** want Florida Gynecologic Oncology and Robotic Surgery to leave any detailed messages on my voicemail, including test results.

☐ I **will allow** Florida Gynecologic Oncology and Robotic Surgery to leave detailed test result information on my voicemail.

Patient Signature: _____

Date: _____

Phone number to leave messages: _____

Zoyla Almeida, M.D., F.A.C.O.G. originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results; diagnoses, treatment, and my plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A toll for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand, and have been provided with a Notice of Privacy Practices that provides a more complete description of uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Zoyla Almeida, M.D., F.A.C.O.G. is not required to agree to the restrictions requested. I understand that I may revoke the consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking the consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Zoyla Almeida, M.D., F.A.C.O.G. reserves the right to change their notice and practices, and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Zoyla Almeida, M.D., F.A.C.O.G. change their notice, they will send a copy of any revised notice to the address I've provided by U.S. Mail.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____ Patient

Signature Date

For Office Use Only

We have been unable to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices, despite an attempt on:

Date: _____ Attempt: _____ Name of Staff Member: _____

PAYMENT POLICIES AND CONSENT TO BILL INSURANCE COMPANY
Florida Gynecologic Oncology and Robotic Surgery

We accept two methods of payment: 1. Self-pay (out-of-pocket) 2. Insurance

Self-Pay: All clients who pay out-of-pocket are required to pay in full at the time of service. Payment can be made in the form of check or credit card. There is a $25 fee for any checks returned from the bank.

Insurance: We are a participating provider with some health insurance companies. It is the responsibility of the patient to check with her insurance to make sure we participate and are in-network. We will submit bills to the insurance company on your behalf if we participate with you insurance and plan. The patient is required to pay her co-pay, deductible, and/or coinsurance which is set by her insurance company. Copay is due at the time of service. Any deductibles and/or coinsurances will be billed to you after your insurance processes the claim and those fees are due at the time you receive your bill.

***Insurance Coverage Only*:** By using insurance you are granting permission for us to communicate confidential information to your insurance company. Please remember that we have no control of, or responsibility for how information is handled once it is released to third parties. Please note that many insurance companies require audits that request information about symptoms, diagnosis, and treatment. When information is requested by your insurance company, we will provide them with the information that they have requested on your behalf.

NOTICE OF INSURANCE COVERAGE AND NOTICE OF INSURANCE CHANGE: I, the undersigned, have provided a copy of my insurance card(s). If my insurance company does not cover for any reason, I agree that I am financially responsible for all charges. I also hereby authorize Florida Gynecologic Oncology & Robotic Surgery to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. Please remember to contact us immediately if your insurance changes for any reason. You are ultimately responsible for the bill. If your insurance changes and we do not accept that insurance, then you are responsible for the bills. My signature below indicates that I understand that I am responsible for notifying the office of any changes in my insurance. I am aware that I am fully responsible for any services provided to me or my family members in the event that my insurance is no longer valid.

Signature: _____ Date: _____

Getting your Lab Results

Please be advised that the results of any lab work or biopsies that are done during your appointment today will take approximately 7-10 days to be processed. If we receive your results sooner than expected we will call you once they have been reviewed by the doctor. Results cannot be given to the patient without the prior approval of Dr. Almeida. Due to her surgical schedule, a minimum of three days per week, Dr. Almeida will not be available to review your results immediately. We kindly request that you wait for our call with your results.

Our Financial Policy

Timely payment of your bills is considered part of your treatment, and all patients are expected to understand and comply with our financial policy. We accept checks, Visa, MasterCard, Amex and Discover. Our fees are based on the usual and customary professional fees for gynecology oncology in the South Florida area. Payment is expected at the time you check in for your appointment. Should your account become delinquent, you will be responsible for all costs of collection, including but not limited t: collection agency fees, court costs, interest and legal fees. All unpaid accounts are reported to the credit bureaus. The parent or guardian accompanying a minor is responsible for the payment of the bill. Patients under the age of 18 will need to be accompanied by a Parent/Guardian. Consent for examination must be signed by the Parent/Guardian.

For Insured Patients

All copays and deductibles are due at the time of your visit. ***Please verify that we are a participating provider of your insurance plan prior to scheduling your visit.*** It is not our responsibility to obtain your benefits and your plan coverage. We will bill your insurance company as a courtesy to you. If we have difficulty obtaining payment from your insurance company we may need your assistance in getting your claim paid. You will be responsible for payment of services not covered by your insurance plan. It is *your* responsibility to understand your plan's benefits and/or limitations. **HMOs that require a referral from your primary care physician prior to your visit are the sole responsibility of the patient.** Our office is not responsible to obtain the referral for patients that have MHO plans. If you arrive without a referral for your visit, and your insurance requires you to bring one, your appointment will be rescheduled.

For Our Self Pay Patients

In order to accommodate uninsured patients we have established self-pay rates. You are responsible for payment when you check in for your appointment. The fee for your office visit does not include the cost of additional procedures that may be required, or the cost of blood/urine testing. You will be billed separately for your lab work, which will be sent to a facility that offers the most economical alternative.