Cenla Family Medicine Associates, LLC

Central Louisiana Foot and Ankle Specialists

Cardiac and Vascular Services of Cenla

Alexandria Gastroenterology Associates

Michael J. Screpetis, M.D. , William McGinty McBride, III, M.D., Michael G. Buck, M.D., Paul T. Sunderhaus, DPM and Maria N. Saucier, DPM, A. Craig Pearce, M.D. and Joseph Hollier, M.D.

1587 North Bolton Avenue, Suite 1100
Alexandria, LA 71303
(318) 445-9823 (Dr. Screpetis)
(318) 448-8905 (Dr. McBride)
(318) 445-9210 (Dr. Sunderhaus and Dr. Saucier)
(318) 443-8090 (Dr. Pearce)
(318) 473-4500 (Dr. Buck)
(318) 473-8188 (Dr. Hollier)

Office Hours M-Friday 7:45 – 5:00

Payment Policy

We have developed the following payment policy in order to avoid misunderstanding and confusion regarding both your and our responsibilities regarding payment for medical services that are received.

1. Payment is required for services at the time they are rendered. For insured patients covered by plans in which we are participants, we will collect applicable co pays and deductibles at the time of service. We accept payment in the form of personal check, cash, and money order, Visa, MasterCard or Discover. We do not accept American Express. There will be a $25 fee charged for any NSF checks returned to this office.
2. From time to time, we will ask you to present your insurance card and we respectfully request that you inform us of any changes in your insurance coverage prior to seeing the physician. We request this cooperation in order to facilitate processing your medical claims accurately and timely to **your** insurance company for **your** medical benefits.
3. In the event that your medical claims are denied for any reason, other than physician office error, payment will become the responsibility of the patient or responsible guarantor.

Wellness Benefits/Preventive Care

This office must be informed **prior** to your visit with the physician, if you plan to use your wellness benefits provided by your insurance policy. It is your responsibility to know what medical services will be covered by your insurance, neither the physician nor his/her staff. If you receive medical services that exceed the limits of your wellness benefits, you are responsible for payment.

If your claim for wellness benefits/preventive care is denied by your insurance company, the balance will be your responsibility.

Do not ask the physician or office staff to change a medical diagnosis for the purpose of securing payment from your insurance carrier. This is an inappropriate request, at best unethical and at worst fraudulent.

Hospitalization

In case of hospitalization, your insurance company will be billed directly and you will be billed for any amount not paid by insurance.

No Show Policy

As our practice has grown, it has become increasingly difficult for us to schedule appointments and to accommodate urgent appointment requests. One way we can address this is to increase the number of available appointments by minimizing patient "no-shows".

We have thereby **instituted a $25 fee for any missed appointment** that occurs without timely prior notice. Cancellations must be received by 5 pm on the business day prior to your appointment.

Since this fee is not covered by your insurance, you will bear complete financial responsibility for it and would be required to pay it before you can be seen again. We appreciate your understanding in this attempt to better serve our patients.

Authorization for Care

By signing that you have received these documents, you are authorizing and consenting to treatment necessary or desirable to the patient's care, including, but not restricted to whatever medication, performance of procedures, laboratory studies, x-ray or other studies that may be used by the Practitioners of **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla**. You are also authorizing and consenting for Cenla Family Medicine Associates, LLC to furnish information to insurance carriers concerning your illness or accidents. You further authorize your insurance company to pay benefits directly to Cenla Family Medicine Associates, LLC for charges relating to your medical care, whether in the office or hospital.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla,** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla** has been given to me and describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of

Privacy Practices may be obtained by forwarding a written request to The Office Manager Cenla Family Medicine, 1587 North Bolton Ave, Suite 1100, Alexandria, LA 71303.

With this consent, **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla**, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla**, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements so long as they are marked "Personal and Confidential".

I have the right to request that **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla**, restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists or Cardiac and Vascular Services of Cenla** may decline to provide treatment to me.

Cenla Family Medicine Associates, LLC
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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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 my identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. 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 services to you, to pay your health care bills, to support the operation of the physician's 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 whom 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 Operation: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health 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 indicate 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 your appointment.

We may use or disclose your protected health information in the following situations without your authorization. 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 Proceeding: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must

make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements 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 physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

1. You have the right to inspect and copy your protected health information. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request for a copy of the medical record. 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.

2. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosures of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

3. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

4. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.