

San Antonio Arthritis Care Centers

Jeffrey A. Feinstein, M.D.

Kenneth F. DesRosier, M.D.

www.arthritis-sa.com

210.590.9596 • Fax 210.693.1491

Thank you for choosing San Antonio Arthritis Care Centers.

We look forward to seeing you on:

Day: _____ Date: _____ Time: _____

With: Dr. Feinstein Dr. Des Rosier

At this location:

8527 Village Dr., Suite 104, San Antonio, TX 78217

You will need to provide us the following before your appointment:

- Medical Release signed
- Current Medication List (enclosed)
- List of all doctors (enclosed)

You will need to provide us the following at your appointment:

- Patient Information Questionnaire (enclosed)
- Copies of all medical records, laboratory and/or X-ray reports that relate to the medical condition you are coming in for
- Health Insurance Card and Photo ID

Please arrive 15 minutes prior to your scheduled appointment time. If you have an appointment that is scheduled more than a week please get all paperwork back to us before the appointment. We can't request medical records if we don't have the form signed and back to us.

If you're initial visit with your physician at San Antonio Arthritis Care Center will be a consultation. The physician will interview you, perform a physical exam, and often times order labs and x-rays. Infusions, injections and other procedures, if appropriate, will be arranged and scheduled at the conclusion of the initial appointment.

If you have any questions, you may contact us at 210-590-9596, Ext. 1101 / Ext. 1102.

If you need to cancel this appointment, please do so at least 48 hours before the appointment to avoid any early cancelation fees. We have a No-Show fee of \$100.00 for New Patients and \$50.00 for all Established patients.

Thank You,
San Antonio Arthritis Care Centers

San Antonio Arthritis Care Centers

Jeffrey A. Feinstein, M.D.

Kenneth F. DesRosier, M.D.

www.arthritis-sa.com

210.590.9596 • Fax 210.693.1521

AUTHORIZATION FOR RELEASE OF COPIES OF PROTECTED HEALTH INFORMATION

Patient's name: _____ Date of birth: _____

SS #: _____ Home phone: _____

Patient's mailing address: _____ Cell phone: _____

City, State, ZIP or postal code: _____ Dates of service: _____

I, _____ (print name) authorize the following health care provider and/or organization to disclose and/or use the following protected health information to the designated person and/or organization for the purpose(s) listed below.

Information disclosed by:	Information received by:
(name of health care provider/organization)	(name of health care provider) San Antonio Arthritis Care Centers
(address)	8527 Village Dr, Ste 103-104, San Antonio, TX 78217
(facsimile number)	(address) 210-693-1521
(phone number)	(facsimile number) 210-590-9596 (phone number)

Check the reports to be disclosed:

- | | |
|--|--|
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Consultation reports |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> All information _____ |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> other, specify _____ |
| <input type="checkbox"/> Radiology reports | _____ |

The information described above may be disclosed for the purpose of: _____

I do ___ do not ___ consent to the disclosure of information pertaining to psychiatric or psychological evaluation or treatment.

I do ___ do not ___ consent to the disclosure of evaluation or treatment of reportable communicable diseases including sexually transmitted diseases and HIV (AIDS).

I do ___ do not ___ consent to the disclosure of substance/alcohol abuse evaluation/treatment.

This authorization shall expire: _____
(Expiration date or event)

I understand the following:

1. I may revoke the authorization at any time (except to the extent that disclosure has already occurred in reliance upon this authorization) by sending a written revocation to the health care provider/organization designated above.
2. Any treatment, payment, or my enrollment in any health plan or my eligibility for benefits will not be affected if I do not Sign this Authorization.
3. Any information disclosed by this authorization to any person/organization not a health care provider or health plan Covered by federal and state privacy regulations could be re-disclosed by the recipient and no longer protected by those regulations.
4. I am entitled to receive a copy of this signed authorization.

(Signature of the authorizing individual)

(Date signed)

(Signature of personal representative with description of authority to act on behalf of the patient)

(Date signed)

San Antonio Arthritis Care Centers

Jeffrey A. Feinstein, M.D.

Kenneth F. DesRosier, M.D.

www.arthritis-sa.com

210.590.9596 • Fax 210.693.1491

PF-1300 Authorization for Use and Disclosure of Protected Health Information

Information to be Used or Disclosed

Information described above may be disclosed to:

Name of Person

Name of Person

Expiration Date of Authorization

This authorization is effective through ____/____/____. Unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to the San Antonio Arthritis Care Centers. You should contact the Privacy Officer to terminate this authorization.

Name of Patient (Print)

Signature of Patient

Date

Signature of Patient's Representative

Relationship

San Antonio Arthritis Care Centers

Jeffrey A. Feinstein, M.D.

Kenneth F. DesRosier, M.D.

www.arthritis-sa.com

210.590.9596 • Fax 210.693.1491

Patient Financial Policy

Thank you for choosing San Antonio Arthritis Care Centers as your health care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with patient account representative.

We accept cash, check, VISA, American Express, MasterCard or Discover. Absolutely no post-dated checks will be accepted. A service fee of \$50 will be charged to your account for all returned checks.

Insurance Claims

There is no doubt that health insurance benefits are confusing. **Most plans do not provide 100% coverage for medical bills.** Each plan has its own set of rules, exclusions and benefit structures. **It is your responsibility to be familiar with your insurance policy's requirements.** If you are unsure of your coverage as it relates to services rendered at our office, you should call the customer service telephone number on your insurance card before receiving those services. Insurance is a contract between you and your insurance company. **We will bill your insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information. Incomplete insurance information may result in patient responsibility for the entire bill.** Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. We collect all fees before and at the time of the appointment.

Participating Insurances

We accept most insurance plans for our patients. Please call our insurance verification department for more information. It is your responsibility to give all new insurance information to our staff before your appointment.

Referrals

If you have an HMO or POS plan with which we participate, you may need a referral from your Primary Care Physician (PCP) to see our Specialist. Check your insurance card or call your insurance carrier to determine if your plan requires you to have a referral to see a Specialist. We must have the referral in the office before you are seen by our Specialist. You will be asked to reschedule your appointment in the event that your referral is not here at the time of your appointment. For this reason, it is important that you make sure that your Primary Care Physician has sent the referral and that we have received it before you come in to the office. Another option is to bring the referral with you at the time of your appointment, but this must be coordinated in advance with our referral coordinator.

Self-pay Patients

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay new patients will be required to bring a flat fee of \$500 at the initial appointment. Only cash or credit card will be accepted. For all subsequent visits, payment is due in full at time of service. Patients paying with check or credit card will be required to pay for services rendered in full. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Missed Appointments

San Antonio Arthritis Care Centers requires 48-hour notice of appointment cancellation. Appointments missed and are not previously canceled may be charged a "No Show" fee of \$50 to established patients or \$100 fee to New patients. Any infusion center appointments missed and not canceled may be charged a "No Show" fee of \$100.

Returned Checks

San Antonio Arthritis Care Centers will charge a service fee of \$50 for a returned check which is payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. You will be placed on a cash or credit only basis following any returned check.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent 3 statements. If payment is not made on this account, a notice of collections will be sent asking you to contact our business office to pay your account in full or make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

Payment plans are available for account balances in excess of \$50 in the event of a financial hardship. Payment terms are as follows: 50% of the total balance must be paid at inception of the payment plan agreement. The remaining balance will be due within 2 months. A bill will be sent to your mailing address each month for the amount agreed upon. If you are delinquent on a payment, your account may be turned over to the collection agency. All charges incurred after the inception of the payment plan will be due with 30 days of receipt of the statement. Failure to comply with these payment terms may result in a dismissal from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our Business Office Monday through Thursday, 8:30 am to 5:00 pm. Please call 210.590.9596.

Authorization to Release Information:

I authorize San Antonio Arthritis Care Centers to release information to my healthcare insurer or the Center for Medicare and Medicaid Services (CMS), or any other entity necessary to determine benefits and process claims related to medical services that have been provided to me. An electronic copy of this authorization will be deemed as valid as the original. I allow a photocopy of my signature to be used to process insurance claims.

Assignment of Benefits:

I authorize payment of insurance benefits, including CMS benefits, for medical services provided to me directly to San Antonio Arthritis Care Centers an electronic copy of this authorization will be deemed as valid as the original. I understand that I am responsible for any amount not covered by my insurance.

Financial Responsibility:

I have read the San Antonio Arthritis Care Centers Financial Policy and understand that I am responsible for all fees for medical services rendered to me by the physicians and staff of San Antonio Arthritis Care Centers. Any fees deemed patient responsibility or are not covered by my insurance company will be **due** on the **day of service** or upon resolution of my insurance claim. **San Antonio Arthritis Care Centers reserves the right to request payment of these fees before my insurance company has completed the processing of my claim (s) or if my claims are denied.** It is my responsibility to notify San Antonio Arthritis Care Centers of any changes in my health care coverage before services are rendered. I understand that by signing this form that I am accepting financial responsibility as explained above for payment for medical services rendered to me. An electronic copy of this authorization will be deemed as valid as the original. A photocopy of this agreement is to be considered as valid as the original.

Patient Signature: _____ Date: _____

Please print your name: _____

Office Calls Policy

Thank you for choosing San Antonio Arthritis Care Centers as your health care provider. We are committed to providing you the best available medical care. We ask that all patients read and sign our office policies prior to seeing the physician.

Payment for service is due at the time services are rendered. We accept Cash, Check, Visa, MasterCard, and Discover.

As of March 01, 2013 San Antonio Arthritis Care Centers will no longer accept phone calls for the following:

MEDICATION REFILL POLICY

LAB RESULTS

MEDICATION REFILL POLICY

You should contact your pharmacy before contacting our office about medication refills. You may already have a current authorized refill, and most local pharmacies will contact our office if you do not have a refill. If you take a medication every day, you should ask your pharmacy for a refill at least five days before the medication runs out as it is impossible to handle each request immediately. If you have any problems getting refills, please call the office right away. Our office handles medication refills during normal working hours Monday through Thursday From 8am to 3pm. We will handle your request within 48 hours. San Antonio Arthritis Care Centers have a policy of not calling in medications for conditions or complaints that they have not been treating. The afterhours paging service is reserved for emergency calls only. No refills on medications will be made over the weekend and Holidays. Also, if San Antonio Arthritis Care Center's doctors have not treated you within a one-year period, you must have an office visit before your refill can be granted.

Some insurance plans require a referral from a PCP. It is the patient's responsibility to obtain this referral in order to be seen by our doctors. If a valid referral is not obtained at the time of appointment, your appointment will be rescheduled.

***After hours non-urgent phone calls or pages through the Message service will be subject to a \$25 fee.**

LAB RESULTS

***Please do not call for lab results.** San Antonio Arthritis Care Centers has **NextMD** so you will be able to register and receive your test results thru the patient portal. You should receive all results within 2-3 weeks. Please use patient portal to request results. You will be called if any medication change needs to be made or any additional test need to be done. **You will receive results at your next visit.** You can schedule an office visit with our staff if you do not have an appointment.

NextMD

In an effort to save time and eliminate phone calls we have implemented a secured internet patient portal with NextMD as a way to communicate with our patients for any medical issues, billing, and/or any results. With NextMD you will be able to communicate directly with your physician on any matter you may have. In order for you to obtain your results you must be signed up with NextMD. If you are not registered with NextMD you will be required to schedule an appointment in order to receive your results. It is necessary for you to be signed up with our NextMD patient portal. This is the best way to communicate with our office; it is a faster and more convenient way to address any issues/concerns you may have. This is similar to a regular email and is a secure website. This site is provided to you at no charge.

NextGen Patient Portal is designed with the patient in mind and the site is user-friendly to ensure quick and easy access with you and your provider.

You will be able to:

- *access your health information**
- *Request to reschedule your appointments**
- *Fill out forms online**
- *Request prescription refills**
- *Request results and request referrals**
- *Receive statements**
- *Pay your bill**

Print Name:

Patient's Signature (Legal Guardian): Date:

Email: