CARTER HAYS MARTIN & ASSOCIATES

OBSTETRICS GYNECOLOGY INFERTILITY

J. G. CARTER, M.D., P.A. TRACY D. HAYS, M.D., P.A. AMY G. MARTIN, M.D., P.A. EDWARD J. POWERS, M.D.

Welcome to our practice. We want to thank you for choosing us as your healthcare provider. In an effort to provide the best care possible, we would like to take a moment and explain a few of our policies.

Updating Information

Please bring a picture ID and your insurance card to each visit-this is to protect yourself and our practice from identity theft. Please be sure we have the most current demographic and insurance information at all times. You will be asked to sign in and complete a new demographic sheet on a yearly basis. Filing claims with incorrect information delays processing and increases patient liability. Please note if you fail to give us updated insurance information at the time of your appointment, we will not be able to file your claim to the correct company after 30 days from the date of your visit.

Appointments

We understand that your time is valuable and we do our best at keeping the schedule running smoothly and on time. Out of respect for all patients we ask that you be on time for each appointment. Any patient who arrives greater than 15 minutes past their scheduled appointment time will be asked to reschedule for a different day.

Should an emergency arise, we ask that you be patient as we do our best to handle the situation and return to seeing patients as scheduled. Unfortunately, it may be necessary for us to reschedule appointments unexpectedly, should this occur we will do our best to notify you as soon as possible and reschedule you at the next earliest time.

Should you need to cancel or reschedule an appointment, please contact the office as soon as possible; 24 hours' notice is appreciated. Failure to notify the office prior to your scheduled appointment 3 times could result in you being dismissed from the practice. A $25.00 no show fee may also be assessed. This fee is not payable by insurance and therefore will not be filed; the patient will be responsible for payment.

Preventive vs. Problem Visit

A preventive service, such as a well woman exam, is a service provided to screen for various illnesses and disease. A problem visit is when the patient has a specific concern, symptom, or complaint. Some insurance carriers only cover services for preventive visits, while others may only cover services for problem visits. We recommend that you contact your insurance carrier prior to each visit and inquire about the type of benefits you have. The more familiar you are with your benefits the less likely you will have unexpected financial responsibility. Payment is due at the time of service, according to your current insurance benefits, this could include copays, deductibles, and co-insurance amounts.

Medicare

We are always glad to see Medicare patients; however we are not participating providers for Medicare. Therefore, payment for your services is due at the time of your visit. We will file your claim for you and you will receive any payment due directly from Medicare. Please speak with our billing department prior to your visit if you have any further questions.

Non-covered Services

A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service. Please contact your insurance carrier and inquire about any service that may be non-covered. If you receive a service that is considered non-covered by your insurance plan, you will be expected to make payment in full for all charges.

Insurance

We are contracted with multiple insurance companies. Some insurance companies have special programs that allow for better benefits for you as the patient. While our physicians may be contracted with the insurance company in general, they may not be a preferred provider under these special programs. We suggest you always verify with your insurance carrier to confirm there is nothing specific about your plan that would exclude our physicians, as it is ultimately your responsibility in making sure that you are seeking care from an in-network physician. Please keep in mind we can never guarantee coverage of a service.

Payment

Our office attempts to verify all patient's insurance benefits prior to their appointment. Any copay, deductible, or co-insurance is due at time of service. We will give you the best estimate possible based off of the benefits quoted. Please keep in mind, sometimes benefits are misquoted by your insurance carrier; however we must collect based off their explanation. Once your insurance carrier has finalized your claim, we will make any necessary adjustments to your account.

Note- While we attempt to be as accurate as we can when verifying your benefits; ultimately knowing your insurance plan and how it pays is your responsibility. We are happy to provide you with information to help you verify your own insurance more accurately. Please feel free to call our billing department with questions. All outstanding balances are due in full upon receipt of statement.

Claims Filing

While we are not obligated to file claims for you with all contracted insurance companies, we are happy to do so as a courtesy to our patients. Secondary insurance plans can be of great assistance in the payment process. We will file deductible and co-insurance amounts to any secondary insurance you provide us; co-payments will not be filed to your secondary. If you have multiple insurance carriers, please make sure each carrier is aware of the other and you provide us with accurate information. An insurance carrier in the patient's name is always primary; you may not choose which carrier to use as primary vs. secondary.

Insurance Billing and Payment

In an effort to reduce patient financial liability, it is sometimes necessary for our billing department to appeal claims. In doing so, it may also be necessary to involve other agencies such as the Texas Medical Association and/or the Texas Department of Insurance. By signing this policy, you agree to allow us to release certain demographical and medical information to these agencies in order to secure payment. Please be assured we will only release information that is absolutely necessary.

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Referrals/Authorizations
Should your insurance company require a referral or authorization, it is your responsibility to obtain or request one prior to your appointment. Please note some insurance carriers will not allow your OB/GYN to issue a referral, you may be required to go through your PCP.

Labs
When you have a pap smear, HPV test, biopsy, culture, or blood work done we will send the specimen to an outside lab. All lab tests will be billed by the appropriate lab. We do our best to forward the most current insurance information we have on file with each specimen. Occasionally this information does not forward properly. Should you receive a bill from the lab due to incorrect information, simply call the lab and provide your current insurance information. A lab draw fee may be assed dependent on insurance coverage and lab requirements. An offsite lab may be necessary to avoid this. If a preferred lab is required, it is the responsibility of the patient to notify the office of such, to ensure proper specimen handling and billing.

Responsible Party/Minors
The patient will be considered as the responsible party for payment purposes. If the patient is under the age of 18 the parent/guardian authorizing care will be responsible for payment of service, at time of service. They will also need to be present at the minor patient's appointment. If a patient is over 18, regardless of who holds the insurance policy, the patient will be responsible for payment of services.

Refunds
Should your insurance process your claim differently than quoted or expected, any refund due to you will be issued.

Surgery Cancellation Fee
There will be a $50 cancellation fee for cancellation of surgery due to non-medical reasons without a 24 hour notice.

Returned Payment
Payment is accepted in the form of cash, check, money order, or credit card. Should a payment be returned for any reason, including but not limited to, insufficient funds, stop payment, or closed account, the patient will be liable for the original amount plus any associated NSF fees. Our current NSF fee is $25.00.

Medical Records
- 1. I understand the Texas State Board of Medical Examiners allows 2 weeks for the processing of my records.

- 2. I understand that if I request medical records there is a fee which must be paid prior to the records being copied and mailed/sent. According to the Texas State Board of Medical Examiners, the allowable fee is $25.00 for the first twenty pages and $0.50 for each additional page.

I have read, understand, and agree to the information and policies set forth in this agreement

_____ _____

Patient Signature Date

1311 NORTH WASHINGTON AVE. • DALLAS, TX 75204 • 214-824-2563

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Consent to Use and Disclose Protected Health Information

How We May Use and Disclose your Health Information

Your protected health information will be used on a need to know basis to your insurance carrier and/or consulting physicians or specialists only.

The Notice of Privacy Practices

Drs. Carter, Hays, Martin, and Powers are required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies" handout and are available to you at your request.

You May Place Restrictions on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information It is a violation of the federal privacy standards if Drs. Carter, Hays, Martin and Powers, agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Handout, please consult with a practice representative.

You May Revoke this Consent at Any Time

You may revoke this consent at any time; however, Drs. Carter, Hays, Martin and Powers requires that you must revoke this consent in writing, If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

Changes to Privacy Practices

Drs. Carter, Hays, Martin, and Powers reserves the right to change or modify the privacy practices outlined in the "Notice of Privacy Handout." Drs. Carter, Hays, Martin and Farris will notify you of any charges of privacy practices either by mail, at your next appointment, or any other pre-approved method that you request.

Signature

I have reviewed this consent form and the "Notice of Privacy Policies Handout" has been made available to me. I give my permission to Drs. Carter, Hays, Martin, and Powers to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____

Name of Patient (Print) Signature of Patient/Date

_____ _____

Patient Representative/Relationship (Print) Signature of Representative/Date

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Insurance/Financial Policy

Our practice accepts most major insurance. As a courtesy to you, we will verify your insurance coverage and file your claim, however, you are ultimately responsible for any charges incurred through our facility whether or not your insurance pays for the services you receive.

What We Require:

1. You *must* provide us with your current insurance information prior to your next appointment. Your insurance identification card along with a picture ID will need to be presented upon arrival for your appointment. If any of your insurance information changes, you *must* report the change to our office immediately. In many cases, even if the insurance company stays the same, the subscriber ID or group number could change. We *cannot* bill your claim unless you give us complete and accurate insurance information.
2. All co-pays, deductibles, and coinsurance are *due at the time of service*. We accept cash, checks and most bank cards.
3. Payments not received from your insurance company within 45 days, will be considered patient responsibility and *must be paid immediately* once you have been notified by our office. Any additional credits that we may receive will be applied to your account and a refund payment *will be sent to you*. Payments not received within 60 days of notice may force us to limit future appointments until balance is paid in full.
4. If an insurance problem occurs, you may need to contact you insurance company to assist is us in getting the problem resolved. *Failure to do so, could result in you being responsible for the balance in full.*
5. Your insurance provider may require an authorization or pre-certification, especially if you are having a specific type of sonogram or procedure. *Please be familiar with your plan's requirements and these services are covered.*
6. The laboratory/pathologist and/or surgical facilities that contract with your insurance company *may not cover all of the services needed for your treatment.* These facilities may forward a separate bill to you for the interpretation of collected specimens or processing of lab tests. *You will need to contact those facilities regarding the charges billed.* For legal reasons, *we will not re-code* select services just so your insurance company will pay then and *we will not negotiate charges* bill by any of the laboratories, pathologists or surgical facilities.

Acknowledgement of Insurance Policy and Assessment of Benefits

I have read and fully understand the insurance policy requirements of Drs. Carter, Hays, Martin and Powers as set forth above. I understand that the benefit coverage amounts quoted by my insurance provider to Drs. Carter, Hays, Martin and Farris *are only an estimate and may be subject to change at my insurance company's discretion.* I hereby direct assignment of my rights and insurance benefits to Drs. Carter, Hays, Martin and Powers. I agree to pay, in a timely manner, any balance owed, due to deductible, coinsurance status or non-covered service. (A photocopy of this assignment shall be considered as effective and valid as the original.)

_____ _____

Printed Name of Patient or Guardian Signature of Patient or Guardian

_____

Date

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Health Insurance Portability & Accountability Act Questionnaire Form (HIPAA)

In an effort to protect your personal information and in compliance with the Health Insurance Portability & Accountability Act, we require that ***you sign and complete*** this form to ensure and acknowledge that this office is following HIPAA policy requirements.

Please initial the following statement:

_____ Protected information may be disclosed or used for treatment, payment, and/or healthcare operations.

Please list your contact preferences below regarding your appointments, labs, x-ray's and other healthcare information. ***By signing this form and completing this section, you acknowledge and are fully aware that a cellular phone is not a secure and private line and that we are not responsible for the U.S. Postal Service sending your mail to an incorrect address.***

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

Billing Address: _____

Alternative Address: _____

May we leave a confidential message on your voice mail or telephone answering machine? Yes or No
*(**We will be unable to leave a detailed message if your name is not recorded on your voice mail box or answering machine**)*

Do you authorize us to speak with anyone (spouse, family, friend, co-worker, etc) regarding your general medical condition, diagnosis, treatment plan, appointments, prescriptions, and /or financial terms? Yes or No . If yes, please indicate below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Your Printed Name: _____ (Guardian if under 18 years of age)

Your Signature: _____ Date: _____

(In order to ensure the accuracy of your protected health information, we will update this form annually)

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THE FOLLOWING FORM
MUST BE READ, SIGNED AND DATED
BY ALL PATIENTS
EVEN IF YOU FEEL
THAT IT DOES NOT APPLY TO YOU.

MEDICAID WAIVER

Drs. Carter, Hays, Martin and Powers do not accept Medicaid or Medicaid products.

Please read and sign the following statement:

Should I become contracted with Medicaid or their products, I am aware that I will be fully responsible for payment of all services rendered to me by Drs. Carter, Hays, Martin and Powers.

_____
Signature of Patient or Guardian

_____
Printed Name of Patient or Guardian

_____
Date

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Annual and Wellness Policy

At times, during your wellness visit, abnormal concerns arise; and there are times when you electively bring concerns to your appointment to discuss with your physician. Your physician will happily address these concerns; either at your annual exam or at a separate "problem visit".

Be advised that when we combine two visits (illness and wellness) into one appointment, your physician has provided additional medical decision making, possibly referred you to a specialist, and/or provided a course of treatment.

Because of recent health care changes, any balance resulting from the additional charges billed may be your responsibility.

Please remember your annual exam is a **preventative** visit and not a **problem** visit.

With your Annual exam, there may be testing other than a pap smear. HPV testing, STD screening and testing for blood in the stool are specific, age related screening tests that are also performed during your annual exam. ***If you decline this testing, please let your physician know.*** We do our best to verify your benefits prior to your visit, but questions regarding any of the above tests are best addressed by contacting your insurance provider directly.

We recognize that there are many different types of insurance and plans available today and that all plans display different types of coverage. While we regret that all visits and lab test may not be covered entirely by your insurance carrier, legally we are unable to alter our medical records or make any kind of code changes to align with your particular benefits.

At Carter, Hays, Martin and Associates we strive to provide an excellent level of care. We hope this letter clears up any confusion for services provided today.

Sincerely,

Drs. Carter, Hays, Martin, and Powers

Patient's Printed Name: _____

Patient's Signature and Date: _____

Date: _____