Arthritis & Osteoporosis Associates

Practice Policies

Thank you for choosing Arthritis & Osteoporosis Associates. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

We are happy to bill your primary and secondary insurance companies directly if we participate with that policy and if a copy of both sides of your insurance card is provided at the time of service as well as all required demographic information necessary to file your claim. If you do not provide the necessary information to file your claim, you will be responsible for payment in full at time of service. You are required to notify us when any demographic or insurance information changes. You are required to provide a copy of your insurance card if your coverage changes. If payment is not received from your insurance company in ninety days, you will be expected to assist in the resolution of the open claim. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

If you have an insurance plan which requires a referral, it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit or procedure.

All patients are required to pay their copay and/or balance at the time of service. We accept personal check, money orders and all major credit cards. Self pay patients are required to pay in full at the time of service. **If you present without the copayment or do not remit copayment within 24 hours of your visit, we reserve the right to bill you a $15.00 administrative fee.** If for any reason a payment is dishonored by your bank, there will be a $35.00 service fee added to your bill and you will be required to pay by cash, certified check, money order or credit card for all future services.

We are participating providers for many plans. However, for those that we are not we encourage you to submit your claims on your own behalf. In the event that your insurance carrier issues payment directly to you, it is your responsibility to forward payment along with the explanation of benefits for appropriate posting of the payment to Arthritis & Osteoporosis Associates.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to collections.

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports or other paperwork will require a minimum fee of $25.00, paid in advance, related to the amount of the preparation involved. Please allow two weeks for completion.

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Appointments

Please be sure to provide a telephone number where you may be reached. If you have a voicemail on your contact telephone number, our staff will leave a message including the time, date and location of your appointment. You can also check our new Patient Portal online for all of your appointment information.

We require 24 hours' notice if you intend to cancel your appointment. Should you neglect to keep your appointment without proper notice, we reserve the right to charge a no-show fee of $50.00 to your account.

If you are late for your appointment, we reserve the right to reschedule your appointment or see you as the schedule permits. If you are a new patient and do not complete your forms in advance, you are required to be at the office at least 25 minutes in advance of your appointment to complete the necessary forms.

HIPPA Privacy

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Arthritis & Osteoporosis Associates. This policy explains your rights including your right to see and copy your records, to limit disclosure of your protected health information and to request an amendment to your record. You may revoke in writing any consent for release of your health care information except to the extent the Practice has already made disclosures with your prior consent. Because of the privacy regulations we are not at liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an additional form to modify this information. By signing this release, you allow us to discuss your care with the specified individual(s). If a family member has concerns about your care, we may not discuss these concerns without your written permission. Our Notice of Privacy Practices provides information on your rights and is available on our website. We encourage you to read it in full. If you have any questions regarding our notice and if we change our notice, you may obtain a copy by contacting us at 732-780-7650 or visiting our website at www.AOADoctors.com.

Authorization to Release Information and Assignment of Benefits

By signing this form, you agree to the following: I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Blue Shield, HMO's, and commercial insurance to Arthritis & Osteoporosis Associates. **I understand that I am fully responsible for all charges whether or not they are covered by said insurance**. I hereby authorize assignee to release any information necessary to secure payment on my behalf.

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Medication Policy

It is important to your health that you follow the directions carefully on all medications that we prescribe. In addition we must be informed of all other medication, prescription, over-the-counter and supplements that you are taking.

Controlled Medications

We will not refill controlled medications in advance of their refill date, regardless of the situation, nor will we mail these prescriptions. They must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make an appointment, we require a two day notice for a medication refill.

Please be advised you will be required to give a urine specimen for drug testing. Automatic discharge from the practice will occur for any of the following; forgery or diversion of the prescription, failure to comply with the recommendation of the physician, and any drug seeking behavior including but not limited to using the medication more frequently than recommended, repeated calling after hours to obtain prescriptions, repeated visits to the ER for pain, use of medication beyond the expected treatment period and failure to notify your physician that you are receiving narcotics from other physicians. You may be referred to a pain management specialist or asked to have an evaluation by a mental health profession to help manage your pain.

Staff

We require our staff to address our patients with professionalism and we ask our patients to do the same. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. We will document our record and depending on the severity of the situation, you may be discharged from the practice.

We are committed to providing the best possible treatment and ask your cooperation in following our policies.

I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

Signature: _____ **(Please sign form in office)**

Print Name: _____ **Date:_____**

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DESIGNATION OF DISCLOSURE

You can disclose my health information as described below:

Please list all phone numbers we may try to contact you on:

Phone #:_____ home/cell/work *(circle one)*

Phone #:_____ home/cell/work *(circle one)*

Phone #:_____ home/cell/work *(circle one)*

Ok to leave message: (check all that apply)

☐ On my answering machine
☐ With my spouse
☐ Leave message with call back number only

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the Practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. I understand that Arthritis & Osteoporosis Associates will not disclose health information to any person not designated except in case of an emergency.

Name: _____ Relation:_____ Phone #:_____

Name: _____ Relation: _____ Phone #:_____

Name: _____ Relation: _____ Phone #: _____

Please list **ALL** physicians you see, in addition to your Primary Care Physician, which may request your records in the future.

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

☐ CHECK HERE TO AUTHORIZE MEDICAL RECORDS RELEASE TO ANY PHYSICIAN THAT MAY REQUEST IT

Print Name: _____

Signature: _____ *Date:* _____