Davis Spine & Orthopaedics

Spine and Orthopaedic Surgeon
Board Certified and Fellowship Trained
www.DavisSpine.com
2800 Windguard Circle Suite 101
Wesley Chapel, FL 33544
Phone: 813-994-BACK (2225) Fax: 813-438-4494

Financial Policy, Office Policies, and Acknowledgement of Notice of Privacy Practices

Thank you for choosing us for your Orthopaedic healthcare needs. We are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and understanding of our payment policy. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. Also included is the patient acknowledgment of the "Notice of Privacy Practices".

Payment for Service is Due at the Time Service is Rendered: We accept cash, checks, Visa, MasterCard and Discover. If you are unable to pay at the time of service, your appointment may be rescheduled unless other arrangements have been made. There is a $40.00 charge for returned checks.

Insurance: We may accept assignment of your insurance benefits. Assignment is taken on a case by case basis. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with your insurance cards and billing addresses. Your insurance policy is a contract between you and your insurance company only. We are not a party to that contract. You are responsible to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance or third party once in receipt of statement. If your insurance company has not paid your amount in full within, you are responsible for the balance due unless prior payment arrangements have been made with our billing manager. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance policy. You are still responsible for payment. If we are not "In-Network" with your insurance company, you remain personally responsible for any and all amounts not paid by insurance and Davis Spine & Orthopaedics is not contractually required to take any adjustments on our charges.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for those medical treatments.

_____ (Initial) I do not wish to use my health insurance for treatment at Davis Spine & Orthopaedics.

_____ (Initial) I do wish to use my health insurance for treatment at Davis Spine & Orthopaedics and I understand the policies of the practice regarding health insurance as further described in this Financial Policy.

_____ (Initial) I do not have health insurance.

Accident or Auto Injury Patients: It is our goal to offer our services to a wide range of patients and understand that some patients may require our care due to injuries sustained, at least in part, by the negligence of third parties. We attempt to bill Personal Injury Protection through your automobile insurer where applicable, and we will refrain from collecting any unpaid or non-covered services until you have concluded your claim. In return, it is your obligation to provide us with the name and contact information of any insurer you wish to have billed as well as your policy and/or claim number at the time of your initial visit. If you fail to provide us with that information, your insurance will not be billed and you will be responsible for the full payment of all charges incurred and to the extent allowed by law. You also understand that any services which are not paid or covered by any insurer will remain your personal responsibility regardless of the outcome of any claim you may have pending against other parties. At the conclusion of any such claim, it is your responsibility to contact our

facility, or instruct your legal representative to contact our facility, to inform us that the claim has been concluded and to arrange final payment for the charges incurred.

During the pendency of any claim for which you have retained legal counsel, we will refrain from collection efforts but strongly encourage you to make payment arrangements for any balance remaining after the payment of insurance benefits to the extent you are financially able. It is your responsibility to inform us of the name and contact information of your legal representative at the time of your initial visit. You are also responsible to notify us of any change in your legal representation within ten (10) days of the change. In the event that you are no longer represented by legal counsel, we will initiate collections efforts within ten (10) days of notification. In the event you have any balance at the conclusion of your claim but do not recover enough to pay the balance, you remain personally liable for the balance and we will commence collection efforts sixty (60) days after the conclusion of your claim if other arrangements to pay the balance have not been made. Balances incurred for our services remain your responsibility regardless of whether the treatment rendered by our physicians or in our facilities are deemed unrelated to the incident giving rise to your claim by any first or third-party insurance carrier, judge, jury, arbitrator, or other finder of fact. You understand and acknowledge that you are freely choosing to receive treatment by our physicians or in our facilities and that you have not been made any promises or received any inducements to incur the expenses of such treatment based upon the outcome of any pending claim you have.

Medical Records Requests: When a patient, physician or other party is requesting medical records, the office may require 5-10 business days for completion of this request, due to the many other office responsibilities to other patients.

No Show Appointments: Patients who do not call to cancel appointments within 24 hours of their scheduled appointment, or patients who no show for their appointment, will be charged a $50.00 fee, and discharged from the practice after the third “no show” or same day cancelation.

Delinquent Accounts: All delinquent accounts will be turned over to an outside collection agency or attorney if balances remain unpaid for a period of 120 days unless arrangements are made with our facility. You are responsible for all fees and charges incurred from the collection agency and/or legal process regarding the settlement of your account.

Office Policies

We make every effort to maintain our telephone service 24/7. During busy periods and after hours you may reach a recording. Please feel free to leave a message and it will be addressed promptly. Dial 911 in the event of an emergency; but, if it is essential that you reach the “physician on call,” follow the instructions on the recording. Please do not call the ‘on call physician’ for refills of medication. There will be a hundred and fifty dollar ($150) fee for these calls and this fee will not likely be covered by your insurance.

We ask that you arrive at least fifteen minutes before all scheduled appointments to fill out follow up paperwork. On the other hand, should you arrive late for an appointment, it may be necessary to reschedule to be respectful of other scheduled appointments. No matter how hard we try, there are those days when we get behind. Should you be in the office on one of those days, please accept our apology. We do make every effort. If you wish we will reschedule; but, if you can bear with us we appreciate it. Also do not leave the office thinking you have been rushed. Should you have any concerns/questions, let us know.

In addition to changes in your medical condition, it is important that you promptly notify us of changes in your name, address, phone number(s) and insurance.

Please bring with you, to all appointments, your ID, your valid insurance card if needed, a referral, co-pay and any materials that may help. This includes a list of your questions (please write them down - it really helps), a list of medications you are taking (prescribed, OTC and herbal), records/reports from other doctors, and images.

Stop at the front desk as you leave each visit. Give a staff member all the papers you were given. Copies need to be made for your record. If you can, schedule your next appointment. Take with you all of your images unless you are pre-op. If left, they may be destroyed.

If you need a form completed, please understand this takes time, typically 10-14 business days, and there is a fee, of forty dollars ($40) to be paid at the time the request is made.

Privacy Practices Signature

CHARLES W. DAVIS II, M.D.-NOTICE OF PRIVACY PRACICES EFFECTIVE FEBRUARY 1, 2019

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to make sure that your medical information is kept private and protected; give you this notice describing our privacy practices and legal duties as well as your rights as they relate to your health information; and follow the terms of this notice that are currently in effect.

We reserve the right to change our privacy practices and this notice. We reserve the right to make changes in our privacy practices and this notice for health information we receive in the future. Before making any significant change to our privacy practices a change to this notice will be made. The new notice will be made visible upon request.

To contact us about this notice please use the contact information which is at the end of this notice.

PERMITTED USES & DISCLOSURES
We may use and disclose your health information for treatment, payment and healthcare operations.
Treatment: We may use health information about you to provide you with medical treatment or services. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you or that has provided treatment to you in addition to your primary care physician.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. This includes sending your health information to an insurance company, billing company or collection agency.
Healthcare operations: We may use and disclose your health information to carry out healthcare operations. This use and disclosure includes quality assessment and improvement activities, reviewing healthcare professionals competence or qualifications, evaluating the performance of a practitioner or provider, conducting training programs, accreditation, certification, licensing or credentialing.
Required by law: We may use or disclose your health information when we are required to do so by federal or state law.
Individuals involved in your care or payment: Unless you say no, we may release your health information to anyone involved in your medical care or payment, such as a friend, family member, personal representative or any individual you identify.
Marketing and fundraising services: We will not use your health information for marketing or fundraising without your permission.
Your consent: You may give us your consent to use your health information or to disclose it to anyone for any purpose. You may revoke your consent in writing at any time. This does not affect our right to use your health

information to carry out treatment, payment or healthcare operations. Without your consent we will only use your healthcare information in carrying out the functions described in this notice.

Public health disclosure: We may disclose your health information for public health purposes such as: preventing or controlling disease, injury or disability, reporting vital events, reporting child abuse and neglect, reporting adverse events or surveillance related to food, medications or defects or problems with products, notifying patients or persons who may have been exposed to a disease or are at risk of contacting or spreading a disease, reporting to an employer findings concerning a work-related illness or injury, and notifying the appropriate government agency as authorized or required by law if we believe a patient has been the victim of abuse, neglect or domestic violence.

Law enforcement: We may release your health information if asked to do so by law enforcement and as authorized and required by law.

Appointment reminders: We may use and disclose your health information to provide you with appointment reminders like voicemail messages, email, postcards or letters.

Coroners, medical examiners and funeral directors: We may disclose your health information to a coroner, medical examiner or a funeral director as necessary to carry out their duties.

National security and intelligence activities: We may disclose your health information as authorized or required by law to authorized federal officials for intelligence, counter intelligence and other national security activities.

YOUR RIGHTS REGARDING HEALTH INFORMATION

Access and disclosure: As a patient you have the right to look at and get copies of your health information, with limited exceptions. Your request must be made in writing and delivered to the privacy officer listed below. We may charge you a reasonable fee for copying your records. We may deny your access, under certain circumstances, such as if we believe it may endanger you or someone else.

Right to and accounting disclosures: As a patient you have the right to receive a list of instances in which we or one of our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities. This right applies to disclosures made after February 14, 2019. You must state the time period for which you want to receive the accounting, which may not be longer than six (6) years. The first request for accounting in a 12-month period will be free. We may charge you a reasonable fee for subsequent requests.

Right to request restrictions: As a patient you have the right to request a restriction on the use and disclosure of your health information. We are not required to agree to those restrictions.

Right to request alternative communication: As a patient you have the right to request that we communicate with you in a certain way or at a certain location. This request must be made in writing. Your request must explain how payments will be handled. We will honor reasonable requests, but if we are unable to contact you using alternative means we will contact you using any information we have.

Right to request amendment: As a patient you have a right to request that we amend or add to your health information. Your request must be **in writing** and explain why the amendment is needed. We may deny your request if the health information was not created by us; is not part of the medical and billing records kept by or for us; is not part of the health information which you would be permitted to inspect and copy; or the health information is determined by us to be accurate and complete.

Right to a paper copy of this notice: As a patient you have a right to a paper copy of this notice. You may ask for a copy at any time.

QUESTIONS AND COMPLAINTS

If you believe that we have violated your privacy rights or have denied one of your rights pursuant to this notice, you may file a written complaint to us. Please send it to our privacy officer at the address below. You may also file a complaint with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint and there will be no retaliation by us.

Privacy Officer: Charles W. Davis, M.D.

Address: 2800 Windguard Circle Suite 101 – Wesley Chapel, FL 33544

Patient Acknowledgement of Davis Spine and Orthopaedics "Notice of Privacy Practices and Patient Right":

I understand that Davis Spine and Orthopaedics has a detailed document in the office for all to read. Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications of alternative location.

I HAVE READ, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY, OFFICE POLICIES, AND RECEIVED NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of Patient or Legal Guardian Date