Practice Policies

Welcome to the Dallas Arthritis and Autoimmune Disease Center. The purpose of this page is to explain our practice policies. These policies are simple and are in place to provide the best and most efficient patient care possible.

- **For your first visit,** please bring with you all important medical records, or call your primary care physician in advance to fax all pertinent records to our office. Your visit might be rescheduled if we do not have the records for your visit.
- Please bring a detailed list or all your current medications/supplements to **every**
- **appointment. For the FIRST appointment,** please arrive 30-40 minutes early to complete all the forms.
- **Late arrivals** of 15 minutes or more will be rescheduled to the next available
- appointment. **Missed appointments:** Because we reserve our time slot for our patients, patients must notify our office with at least a 24-hour notice to reschedule or cancel an appointment. If patient reschedules
  with a less than 24-hour notice, cancel, or No-Shows, the established patient will be charged a fee of $25 and new patient will be charged a fee of $50 before scheduling any further appointments.
  After No-show for 2 visits, we will be unable to schedule any future appointments.
- We ask that every patient has a primary care physician (PCP). **General health questions should be addressed by your PCP.**
- Returning patients need to have labs performed at least 4-7 days prior to your appointment.
- For prescription refills, please call your pharmacy at least 72 hours in advance. The pharmacist will send our office a request for your refill. Refills will be called in within 72 hours after receiving the request.
- **FORMS FEE:** NO FORMS will be filled out on the FIRST visit or until your work up is completed and treatment has started and a response to therapy has been monitored. After receiving your form, provider will check for medically appropriateness, no guarantee that forms will be filled out. Allow 10 – 15 business day turnaround time for forms to be filled out, once form is received and fees are paid in full. Please inquire at the front desk for form fee schedule.
- **Returned Check:** Any returned check for insufficient funds will have a service charge of
- $30.00. Update your phone number, mailing address, and pharmacy at each visit.

Signature

____

Printed name over signature

Date

____

Month-Day-Year

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Basic Information

Name **Date of Birth**

____

First Name Last Name Month-Day-Year

Email ________________

example@example.com

Address

____

Street Address

____

Street Address Line 2

____

City State / Province

____

Postal / Zip Code

Phone Number (Home/Cell) **Social Security Number**

________________________ ____________________

Please enter a valid phone number.

Can your mobile phone receive text (SMS) and/or video calls?
- Yes
- No

May we leave a detailed message with health information on the phone number listed above?
- Yes
- No

Marital status
- Married
- Single
- Divorce

Gender
- Male
- Female

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Occupation: ___________________________________

Employer/work phone number: ____________________

Pharmacy Name and Address

____

Pharmacy Phone number (Area code) (Phone number): ____________________

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GUARANTOR INFORMATION

Please provide details about the person responsible for the bill if different from the patient.

Name of the Guarantor **DOB of the Guarantor**

____

First Name Last Name Month-Day-Year

Phone Number of the Guarantor **Email of the Guarantor**

__________________________ __________________________

Please enter a valid phone number. example@example.com

Relationship with the Guarantor

____

EMERGENCY CONTACT

Name

____

First Name Last Name

Phone Number

____

Please enter a valid phone number.

Relationship

____

INSURANCE INFORMATION

1.

____

Primary Insurance Policy number/member ID Group No.

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Subscriber's Name | Relationship to the subscriber (self, spouse, child)

2.

Secondary Insurance | Policy number/member ID | Group No.

Subscriber's Name | Relationship to the subscriber (self, spouse, child)

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Controlled Medication Prescription Policy

Dear Patient,

Please be advised that Dallas Arthritis and Autoimmune Disease Center, PLLC is strictly a non-narcotic practice, and our office does NOT prescribe controlled medications; occasionally exceptions may be made for brief periods at the discretion of the treating provider.

Dallas Arthritis and Autoimmune Disease Center, PLLC does NOT maintain samples or supplies of narcotic, benzodiazepine, or other controlled substances in our clinic.

If you feel that you require stronger pain medication for your symptoms, then you may be referred to a pain specialist for further relevant management.

Thank you for your understanding and cooperation.

Sincerely,
Dr. Pooja Kumari

Name ______________________
Patient's Name

Relationship ______________________

Signature ______________________
Signature of patient or Authorized Representative

Date ______________________
Month-Day-Year

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If you agree, please place your initial in each box

CONSENT TO MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could possibly require examination, diagnosis, and treatment. I do hereby voluntarily consent to such examination, diagnosis and treatment services and procedures that may be recommended under the general and specific instructions of the physician of Dallas arthritis and autoimmune disease center, their assistant, or designees. I acknowledge that the practice of medicine is not an exact science and that the physician of Dallas arthritis and autoimmune disease centers have made no guarantees to me as to the result of examination, diagnosis, or treatment. Dallas arthritis and autoimmune disease center recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition

INFORMED CONSENT FOR THE USE OF ELECTRONIC HEALTH RECORD

Dallas Arthritis and Autoimmune Disease Center has implemented an electronic health record (EHR) in part to meet the US Department of Health and Human Services initiative to improve health information technology towards the goal of improving quality of healthcare. Our EHR integrate your clinical record with appointments, registrations, billing and making this information available to the clinicians who are involved in your healthcare. In connection with this electronic communication system, Dallas Arthritis and Autoimmune Disease Center has also implemented and has in place privacy and security policies and procedures to minimize the risk of inadvertent and unauthorized disclosure, corruption and/or loss or distortion of data, but as with all the record keeping systems whether paper or digital, some risk retains for loss, inadvertent disclosure, or errors in the recorded data. I have read and understand the information provided regarding electronic health record, have discussed it with my physician or such assistant as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for all the electronic health record usage including electronic transfer of medical data to the other medical practitioner participating in my medical care. I hereby authorize Dallas Arthritis and Autoimmune Disease Center to use EHR during my diagnosis and treatment and consent to electronic communication of my personal healthcare information to other entities for treatment, payment, or healthcare operations.

INFORMED CONSENT OF PRESCRIPTION

Dallas Arthritis and autoimmune disease center continues its position as the network exchange for the flow of vital patient information to physicians and other healthcare providers. It is essential to improve patient safety and continuity of care with electronic connectivity between payers, physicians, and pharmacists. Dallas Arthritis and Autoimmune Disease Center Electronic Health Record (HER) provides secure access for patients with commercial prescription coverage in the United States. Prescription eligibility, benefit, formulary, and medication history information is provided for consenting patients to authorized physicians

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at the point of care. Electronic prescriptions are delivered in real time to pharmacists in the retail and mail order settings. I consent to Electronic Prescription and acknowledge that Dallas Arthritis and Autoimmune Disease Center will use electronic connectivity between payers, physicians and pharmacists.

CONSENT TO USE INFORMATION

☐ I understand that the physician's office may collaborate with other health care providers or team/staff to coordinate, manage, and provide health care to me and I consent to the physician office sharing my health information and records electronically for the purpose of treatment, payment, and or operations. Including the overall quality health care services provided to me. I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information and mental health and substance abuse, etc. The physician's office has implemented administrative physical and technical safeguards that reasonably and appropriately protect confidentiality and integrity of my medical information as required by HIPPA.

ASSIGNMENT OF BENEFITS

☐ I hereby authorize payment of medical benefits directly to Dallas Arthritis and Autoimmune Disease Center, and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. I understand that the benefits may be payable to me directly if I do not provide these authorizations.

FINANCIAL RESPONSIBILITIES

☐ I understand that I am financially responsible for the total charges of services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Dallas Arthritis and Autoimmune Disease Center. I further understand that should my account become delinquent; I shall pay the reasonable attorney fees or collection expenses of Dallas Arthritis and Autoimmune Disease Center, if any.
The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

DISMISSAL

☐ Dallas arthritis and Autoimmune Disease Center PLLC, reserve the right to dismiss patients for delinquent financial accounts on personal balances, inappropriate behavior, physical or sexual harassment, non- compliance, inappropriate demands that are not medically necessary, considered harmful to patient or against our office policies. If dismissed, medical care will not be

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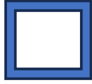
withheld for a medical emergency from 30 days from date of dismissal.

PERSONAL VALUABLES



I understand that the physician's office does not accept responsibility for any lost, stolen and/or damaged personal items while I am at the physician's office.

Signature

____
Printed name over signature

Financial Policies

Thank you for choosing us as your rheumatological care provider. We are committed to providing you with quality and affordable healthcare. We have developed the following payment policy for our practice period please read them, ask us any question you may have, & in the space provided. A copy will be provided to you upon request.

1. **PAYMENT**: payment is expected at the time of your visit. Just as we make every effort to accommodate you when you need medical care, we expect that you will make it every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of the statement from the billing office. We will accept cash, checks, debit, or credit card. We also accept FSA and HSA card payments. Payment will include any unmade deductibles, Co-insurance, Copayment amount or non- covered charges from your insurance company. If you do not get insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of your current insurance card and driver's license at the time of your visit, to ensure that we properly file your claim.

2. **INSURANCE**: We participate with several insurance plans and will file your claim on your behalf. Verification of participation with the patient's specific insurance plan is a responsibility of the patient. Patients are encouraged to contact their insurance carrier to ensure participation with the insurance plan prior to arriving for an appointment.
You are expected to present your insurance card at each visit. Insurance claims are filed to participating insurance companies. The patient is responsible for notifying our office of any changes in insurance coverage. Insurances often

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require a referral to be sent by your primary care provider with an authorization number, it's patient's responsibility to make sure their primary care provider has sent us the proper referral with a proper authorization/referral number which is required to submit your claim for the payment. If your insurance company decline to accept that authorization/referral number, it's patient responsibility to make a full payment for date of service to the physician office.

3. **SELF-PAY:** payment in full is expected at the time of service for uninsured patients.

4. **RETURN CHECKS**: Checks returned for insufficient funds will incur a service charge currently set at $30, which may vary from time to time as determined by our financial institution. If your check is returned, it may be represented electronically. You authorize us the service charges and processing fee, as permitted by state law, to be debited from the same account by paper draft or electronically, at our option.

5. **REFUNDS:** Refunds are issued to patients when a patient overpayment has occurred and there are no outstanding claims to insurance or upcoming appointments scheduled.

6. **COLLECTION ACCOUNTS:** All outstanding balances shall be due within 30 days of date of service. At that time all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 30 day or more after the original billing statement maybe referred to a collection agency and could affect your credit.

7. **FINANCIAL DISMISSAL:** Patients who do not make payment arrangements, risk being dismissed from the practice. Dallas Arthritis and Autoimmune Disease Center reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for 30 days from the date of dismissal.

8. **PAYMENTS AFTER DISSMISAL:** If patient is dismissed from the practice at their own will or per our dismissal policy and for the reason of no further care required by this specialty, all the payments for the date of service are patient's responsibility to pay in full, if services are not covered by their insurance.

9. **RECOUPMENT OF PREVIOUS PAID SERVICE BY INSURANCE:** Your insurance company may pay the balance for the date of service and later decide to recoup the money for any reason months and sometime years later. In that case it will be billed to you and it's your responsibility to pay the amount in full.

10. **FORMS:** Form fees must be paid in full before forms are filled, for specific form fee please inquire our front desk staff.

11. **MISSED APPOINTMENTS:** If patient reschedules with a less than 24 hour notice, cancel, or No-Shows, the established patient will be charged a fee of $25

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and new patient will be charged a fee of $50 before scheduling any further appointments.

12. **METHOD OF PAYMENT:** We accept cash, checks, debit card and credit card for payment. We also accept FSA and HSA card for payments. For any specific billing inquiries or to pay by phone with a credit or debit card please call 903-508-4230. Payment may also be mailed to Dallas Arthritis and Autoimmune Disease Center, 425 N highland Ave. STE 200, Sherman, Texas 75092. Checks are payable to: Dallas Arthritis and Autoimmune Disease Center OR Arthritis & Autoimmunity Clinic.

ACKNOWLEDGEMENT OF FINANCIAL POLICIES

I understand that I have received and understand the financial policy of the Dallas Arthritis and Autoimmune Disease Center. I have asked and cleared any questions I may have with the and I agree to the Dallas Arthritis and Autoimmune Disease Center financial policies.

Signature

____
Printed name over signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices is available online on our website www.dallasarthritis.com to review. I hereby acknowledge that I have reviewed and understand the Notice of Privacy Practices. You may request to receive a copy of the notice of privacy practice for the above medical practice i.e., Dallas Arthritis and Autoimmune Disease Center. I further acknowledge that any amended notice of privacy practices will be made available at my next appointment upon my request

Signature

____
Printed name over signature

To be completed if the patient refuses to sign the acknowledgment

Reason for refusal: ____

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WHO TO CONTACT

I hereby give permission to Dallas Arthritis and Autoimmune Disease Center to disclose and discuss any information related to my medical conditions with the following family member(s), relative(s) and or other person(s).

___ Yes

___ No

If select yes, indicate the information of the person(s) below:

Name of the person (s):	Relationship to the person(s):
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that a request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature	**Date**
______________________________	______________________
Printed name over signature	Month Day Year

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