Katy Rheumatology & Associates, P.A.
19770 Kingsland Blvd, Suite 305, Houston TX 77094
Tel: 281-578-7438 Fax: 281-578-7450

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: (_____) _____ Email: _____

Information regarding healthcare provider or healthcare entity authorized to disclose this information:
Name: Katy Rheumatology & Associates, PA
Address: 19770 Kingsland Blvd #305 City: Houston State: TX Zip Code: 77094
Phone: (281) 578-7438 Fax: (281) 578-7450

Specific information to be disclosed:

□ Medical Record from (insert date) _____ to (insert date) _____
□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
□ Other: _____

Include: (*Indicate by Initialing*)
_____ Drug, Alcohol or Substance Abuse Records
_____ Mental Health Records (Except Psychotherapy Notes)
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)
□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iii) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(iv) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

Acknowledgement of Review of Notice of Privacy Practices

Katy Rheumatology is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our organization and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Katy Rheumatology & Associates.

Name: _____ ✘ _____

Signature of Patient

_____ ✘ _____

Name of Patient or Personal Representative **Signature of Personal Representative**

_____

Description of Personal Representative's Authority

Release of Information: I authorize Katy Rheumatology & Associates to release my private healthcare information to the following family/friend.

Print Name of Family Member/ Friend	Phone Number	Relationship

□ I DO NOT AUTHORIZE Katy Rheumatology & Associates to release my private healthcare information to any family member or friend.

***E-Mail:** _____ **Can we correspond with you by e-mail? □ Yes □ No**

Consent for Treatment:

I consent for medical services and treatment from the physicians and staff of Katy Rheumatology & Associates.

Payment Policy:

Co-payments, co-insurance or deductibles require payment at the time of service. If you have insurance coverage with a managed care plan, it is your responsibility to ensure we are a contracted physician. It is your responsibility to ensure which lab is your contracted lab through your insurance plan. If your insurance requires a referral to see a specialist, it is your responsibility to make sure there is a current referral on file with our office. You are responsible for timely payments on your account.

Cancellation and "No Show" Policy:

There is a cancellation or no show fee of $50.00 if you do not call within 24 hours of your scheduled appointment.

INSURANCE REFERRALS OR AUTHORIZATIONS: If you have an HMO or POS policy requiring an authorization or referral from your primary care physician, it is your responsibility to obtain one. Please make sure you have a valid referral for each visit.

MEDICAL RECORDS: $30.00 for the first twenty-five pages and $.50 per page for every copy thereafter. A reasonable fee for actual costs for mailing, shipping, or delivery. Please allow two week notice for releases.

BILLING STATEMENTS: Please call our billing office for questions regarding your bill at 281-578-7438 Ext 4.

INFORMATION REGARDING TEST RESULTS

Lab results or diagnostic results are usually ready within 5 – 10 business days. **If you have questions please call your nurse if you have NOT received your results within fifteen (15) business days. Normal lab results** will be posted on web portal. **Abnormal lab results** will be called to you or emailed via Patient Portal.

PRESCRIPTION REFILLS: Refills for prescriptions will **NOT** be authorized after hours or on weekends. Please call our office on regular business hours or have your pharmacy fax requests to us. Pain medication will **NOT** be refilled after business hours or on weekends.

✘_____ **Date:** _____

Signature of patient

Katy Rheumatology
& Associates, P.A.

AUTHORIZATION TO RELEASE INFORMATION

"I HEREBY AUTHORIZE THIS PRACTICE TO MAKE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO PROVIDE, COORDINATE, OR MANAGE MY HEALTH CARE AND ANY RELATED SERVICES. THIS INCLUDES THE COORDINATION OR MANAGEMENT OF MY HEALTH CARE WITH A THIRD PARTY. (INFORMATION ABOUT ME IN MY MEDICAL RECORDS AND/OR FINANCIAL RECORDS) AS INDICATED BELOW." THIS INFORMATION IS TO BE DISCLOSED TO:

KATY RHEUMATOLOGY ASSOCIATES
PADMA CHIMATA M.D.
JASMINE SANDESARA DC, FNP-BC
19770 KINGSLAND BLVD. #305
HOUSTON, TEXAS 77094
281-578-7438 FAX: 281-578-7450

PATIENT NAME: _____

PATIENT ADDRESS: _____

DATE OF BIRTH_____

DESCRIPTION OF INFORMATION TO BE DISCLOSED_____

REASON FOR REQUESTED USE OR DISCLOSURE_____

TO BE READ AND SIGNED BY PATIENT

I UNDERSTAND THE FOLLOWING:

A. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING WRITTEN NOTICE TO THIS PRACTICE.
B. I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF THE PRACTICE HAS ALREADY TAKEN ACTION UTILIZING THIS AUTHORIZATION OR IF THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE.
C. THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT BASED ON MY SIGNING THIS AUTHORIZATION.
D. I AM SIGNING THIS AUTHORIZATION FREELY.
E. NO ONE HAS PRESSURED ME TO SIGN THIS AUTHORIZATION.
F. THE INFORMATION DISCLOSED IN THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE PRACTICE AND NO LONGER PROTECTED UNDER FEDERAL LAW.
G. I ACKNOWLEDGE THAT I HAVE HAD AN OPPORTUNITY TO REVIEW THIS AUTHORIZATION AND UNDERSTAND THE INTENT AND THE USE.
H. IF REQUESTED, I WILL RECEIVE A COPY OF THIS AUTHORIZATION.

PATIENT SIGNATURE_____DATE_____

SIGNATURE OF PATIENT REPRESENTATIVE_____DATE_____

UNLESS REVOKED IN WRITING THIS AUTHORIZATION WILL REMAIN IN EFFECT INDEFINATELY

Katy Rheumatology & Associates
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FOR NEW PATIENT CONSULTATIONS THE VISIT WILL LAST FOR APPROXIMATELY 2 TO 3 HOURS.

APPOINTMENTS

Office hours are by appointment only. Our staff and physicians will make every effort to accommodate urgent add on requests. Patient's arriving early for their appointment may not be taken until the scheduled time, to avoid delaying other patients unnecessarily. Patients arriving late for their appointment may need to reschedule.

MEDICAL RECORDS, LABS AND XRAYS

For your appointment, please bring with you all medical records, lab results, x-rays and/or MRI results for the doctor's review during your consultation. Or, have your referring physician, PCP and/or previous Rheumatologist sends your records to us as soon as possible to make certain we have them prior to your scheduled appointment. Without records your rheumatology specialist may not be able to complete your exam. Please call your referring physician in advance of your appointment to make sure your records have been sent.

REFFERALS

If your insurance plan requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We may not be able to see you if a referral is not on file with our office by the scheduled appointment date, unless you decide to pay OUT OF POCKET.

MISSED APPOINTMENTS

We reserve your appointment exclusively for you. We request 24 hours' notice for rescheduling or cancellation of an appointment so that we may schedule another patient on our waiting list. **Failure to cancel or reschedule your appointment within 24 hours of scheduled appointment will result in a $50.00 office fee. You may call and leave a voicemail or contact us through your portal.**

LAB TESTS

We want to be sure you understand that there may be additional blood tests or other lab tests required as part of your evaluation. **The lab tests are handled by a separate facility, and charges for these tests will not be part of your bill from this clinic.** You may receive a bill from the facility that performs any additional tests. We have Lab on site for your convenience. However, if you or your insurance prefers a different facility, please let our physician assistant know before the doctor sees you.

LABS AND X-RAYS REPORTS

1) Labs and X-rays within normal range will not hear from us and will be discussed by the physician on follow up visit.
2) Patient with abnormal labs MUST keep their follow up appointments to discuss the results and for further recommendation by the physician
3) Office staff will not be able to discuss in detail with you in regards to abnormal labs or X-rays, due to lack of qualification
4) Depending on your problem, please allow 24-72 hours for your telephone issues to be addressed.

INSURANCE AND FINANCIAL POLICY

All office visit co-payments, deductibles and co-insurance for professional services are due at the time they are rendered. Please let us know immediately if you have a financial question or problem, so that we are able to assist you.

As a courtesy our patients, we will be happy to bill your health plan if you provide us with the necessary information**. If your Health plan has changed since your last visit, it is your responsibility to inform our staff of the change, to ensure proper resolution when processing your medical claims.**

To help better serve our patients, we ask that all patients get to know the details of their insurance policies thoroughly. There are always limitations and exclusions to coverage. Becoming familiar with the coverage of your insurance will help combat any misconceptions during the billing process. Please contact your health plan if you are unsure about what is covered or not-covered.

Please note that any balance unpaid by your insurance carrier will become your financial obligation. If your health plan has not paid your claim within 45 days, you may be billed.

If you pay by check and your check is being returned to us due to "insufficient funds" or for whatever reason, there will be a **$30.00 service fee**. We will no longer receive check payment from you and all future payments must be paid in Cash or by Credit Card only.

DISABILITY FORMS/ FMLA

If absolutely necessary patients applying for disability needs to be reviewed by Dr. Chimata first in order to determine eligibility. Should your forms be subject to completion, **a separate fee of $150.00 will be assessed per case, per completed form and collected prior to the completion of the associated paperwork.**

REQUEST FOR MEDICAL RECORDS

There will be no charge when records are sent directly to a medical provider for continuing care. **There will be a charge of $30.00 for medical records for the first 25 pages then $0.50 per page, when sent to any party other than a medical provider, including when given to a patient.**