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 & Asociates.

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	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 $30 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 pages and $.50 per page for every copy thereafter. A reasonable fee for actual costs for mailing, shipping, or delivery. Please allow two weeks 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 fifeteen (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 (or parent/guardian if a minor)