

Wakulla Urgent Care & Diagnostic Center
2615 Crawfordville Highway, #103, Crawfordville, FL 32327
David Keen, M.D.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

I, _____ (Print name) have received a copy of the Patient Bill of Rights and Responsibilities and have read them or had them read to me.

Signature of Patient

Date

Signature of Staff Member

Date

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**PATIENT FINANCIAL RESPONSIBILITIES
 AND BILLING INFORMATION**

Thank you for choosing the Wakulla Urgent Care & Diagnostic Center as your provider of health care services. We believe it is important that we communicate our patient financial policies with you. Our office staff will be happy to help you with any questions you may have.

Your Initials	As a Patient/ Parent / Guardian, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or co-payments and other plan provisions that may impact your financial responsibility.
Your Initials	While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all changes. You are responsible to notify our office staff of your insurance and to provide all the necessary information about your insurance plan.
Your Initials	You are responsible for co-payments, co-insurance or deductibles. These payments are due and payable at each appointment when requested. Wakulla Urgent Care & Diagnostics Center is required to collect your co-payment at the time of service because Wakulla Urgent Care & Diagnostics Center is contracted and obligated to do so by the insurance company as a part of its agreement to extend service to their members.
Your Initials	If you are utilizing your insurance benefits, you agree to assign payment from your health plan to the provider. It is your duty to notify this office if you have had a change in insurance.
Your Initials	It is also your duty to ensure that the physician you are seeing is on file as your Primary Care Provider with the insurance, if these do not match you will be responsible for charges incurred because insurance will not pay.
Your Initials	If your account has an outstanding balance, you will be asked to pay all or a portion of the balance before being seen.

Your signature below certifies that you have read and understand all information as stated above.

Patient Name: _____ D.O.B.: _____
 Parent / Guardian's Printed Name: _____
 Signature of Patient/ Parent / Guardian: _____ Date: _____

Billing Information:

- We accept most forms of insurance, including Healthy Kids, Buena Vista, Straight MCD, Medipass, United Healthcare, BCBS, Aetna, Cigna, Tricare and many more. We will work with you to make sure that insurance paperwork and claims are filled in a timely manner.
- Wakulla Urgent Care & Diagnostic Center will conduct credit and collections procedures in accordance with the law.

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**SUMMARY OF THE FLORIDA PATIENT'S BILL
OF RIGHTS AND RESPONSIBILITIES**

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

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A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

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NOTICE OF PRIVACY PRACTICES AND PATIENTS' RIGHTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND YOUR RIGHTS AS A PATIENT. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices, effective November 1, 2011, describes how we may use and disclose your protected health information for treatment, payment or healthcare operations, and for other purposes that are required or permitted by law. It also provides your rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

We reserve our right to revise, make new policies, or change the terms of this notice. Any revisions to our privacy practices will apply to all protected health information that we maintain at that time. We will post a notice of any revised practices in a prominent place on our premises.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

All departments and offices comprising our practice, will use, share and disclose your protected health information as necessary for quality health care, treatment, payment, and our health care operations. We will not ask you to sign a consent form for uses and disclosures that are allowed, as described in this notice. Otherwise, your written consent will be maintained on file; and you have the right to revoke your consent, unless we have taken action in reliance on your authorization. Your consent to and acceptance of our services will mean that you have consented to our use and disclosure of your protected health information, as provided in this notice.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including your surgical procedures, drug study participation and/or eligibility, and all in-office ancillary healthcare services provided by our organization. This also includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose your protected health information to other outside physicians who may be treating you when we have the necessary permission from you to disclose your protected health information.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits.

Health Care Operations. We will use and disclose your protected health information as necessary to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing activities, drug study/recruitment activities, clinical improvement, professional peer review, business management, accreditation/licensing, and conducting or arranging for other practice-related business activities.

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Additionally, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. When your physician or other staff member is ready to see you, we may call you by name while you are in the waiting area. We may use or disclose your protected health information, as necessary, to contact you for appointment or other reminders or notifications.

Business Associates. At times it may be necessary for us to provide your protected health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, billing, legal services, etc. These business associates are required to properly safeguard the privacy of your information. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Appointments and Services. Our office and associated health care operations may contact you to provide appointment reminders or information about treatment alternatives, drug studies, or other health-related benefits and services that may be of interest to you.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may further use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In such case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends. With your written approval, and using our best judgment, your protected health information may be disclosed to designated family, friends, and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies. We may use and disclose your protected health information in an emergency treatment situation. Should such an emergency arise, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If our physician is required by law to provide treatment and we have attempted, but have been unable, to obtain your consent, we may still use or disclose your protected health information in rendering treatment to you.

Communication Barriers. We may use and disclose your protected health information if your physician attempts to obtain your consent but is unable to do so due to substantial communication barriers, and the physician determines, using professional judgment, that you intend to consent to such use or disclosure under the circumstances.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations, without your consent or authorization:

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Required by Law/Public Health. Releases required by law and/or public health activities (e.g. disease, injury, birth/death reporting) and public health investigations;

Abuse or Neglect. Releases required for suspected child abuse or neglect, or if you are suspected of being a victim of abuse, neglect, or domestic violence;

Food and Drug Administration. Releases to the Food and Drug Administration for reporting adverse events, product defects, or for product recalls;

Employment. Releases to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;

Regulatory Agencies. Releases legally required to a government oversight agency conducting audits, investigations, or civil/criminal proceedings;

Legal Proceedings. Releases pursuant to a court order, administrative ordered subpoena or discovery request; in most cases you will have notice of such releases;

Law Enforcement. Releases to law enforcement as legally required for reporting wounds, injuries, and crimes;

Coroners and Funeral Directors. Releases to coroners and/or funeral directors according to applicable laws;

Organ Donation. Releases for organ/tissue donation or transplantation, according to your written instructions, or other legal directives;

Military Requirements. Releases for military requirements, armed forces services, or if necessary for national security or intelligence activities;

Workers' Compensation. Releases to workers' compensation agencies, as applicable to your workers' compensation benefit determinations;

Research. Releases to researchers when their research has been approved by an institutional review board; and

Inmates. Releases if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

PATIENTS' RIGHTS NOTIFICATION

You are entitled to certain rights that you may exercise as described below.

Access to Protected Health Information. You have the right to copy and/or inspect much of your protected health information that we retain on your behalf, and that is contained in a designated record set, for as long as we maintain such protected health information. A "designated record set" contains medical and billing records and any other records that your physician and our office used for making

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decisions about you. Your request to access your protected health information must in writing, dated, and signed by you or your legal representative. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action, and protected health information that is subject to law that prohibits such access. In some circumstances, you may have a right to have reviewed any decision denying your request for such protected health information.

Amendments to Protected Health Information. You have the right to request in writing that your protected health information that we maintain in a designated record set, be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To qualify for consideration, your amendment request must be in writing, dated, and signed by you or your legal representative, and must state the reasons for the requested amendment/correction. Should we make an amendment/correction that you request, we may also notify others within our organization(s) for the amendment/correction of your records that they maintain.

Accounting for Disclosures of Protected Health Information. You have the right to receive an accounting of certain disclosures of your protected health information that we make, after November 1, 2011. Requests must be made in writing, dated, and signed by you or your legal representative.

Restrictions on Use and Disclosure of Protected Health Information. You have the right to request restrictions on certain of our uses and disclosures of your protected health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable and legal requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe the termination is appropriate. Should we terminate a request, we will notify you. You also have the right to terminate any restriction you impose on us, by providing our organization with a written termination, dated, and signed by you or your legal representative.

Alternative Means/Alternative Locations. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests for alternative means of communications and/or locations. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request to our Privacy Officer.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with our Compliance Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Access Fees. We will impose reasonable cost-based fees for certain work and expenses that we incur at your request to provide you with access to information. Such access fees may be imposed for copying, including supplies and labor, postage, and labor in the preparation of explanations or summaries of your protected health information. Such fees will be billed to you as the result of your request for your information and you agree, herein, to pay such fees as charged.