DESERT SKY

SPINE & SPORTS MEDICINE

Musculoskeletal Medicine • Nonsurgical Spine Care
EMG/Nerve Conduction Studies • Work Injuries • Sports injuries

AUTHORIZATION TO RELEASE RECORDS

Patient: _____ Social Security#: _____

Phone: _____ DOB: _____

To: _____

_____

_____

Phone: _____

Fax: _____

I hereby authorize and request the release of

[ ] ALL medical records and correspondence in my file.

[ ] The following records only _____

Please Send Records To:

Desert Sky Spine & Sports Medicine
12450 N Rancho Vistoso Blvd. #110
Oro Valley, AZ 85755
Phone: (520) 229 2080 Fax: (520) 229 2092

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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Payment Policy:
Payment is expected at time of service. Your copay, coinsurance, and/or deductible is due at time of visit. For your convenience, we accept cash, checks, Visa, or MasterCard as a form of payment. Please note that hospitals and surgery centers charge additional and separate fees for any procedures at their facilities. You will be responsible for payment of any remaining balances from both entities after insurance is billed.

Insurance Policy:
If we are covered as one of your insurance companies' network providers you are required to submit your copayment in advance of your appointment. We also will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility.
For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility.
Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance changes.

Non-Covered Service Policy:
Certain services performed by our office are NOT COVERED by all insurance plans. Some of these services include Urine Drug Screens (UDS) and certain injections. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.

Delinquent Accounts Policy:
Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

Medical Records:
Should you request a copy of your medical records, please allow our office 7-10 business days for completion.

Forms Policy:
Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a charge of $25.00 per form. Payment of this charge is expected at time of completion.

Prescriptions:
Please contact our office a minimum of 5 days prior to your scheduled refill date.

Returned Checks:
Our office charges a $25.00 fee for all account closed, stop payment or non-sufficient funds returned checks.

Referrals & Authorizations:
If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware authorizations and referrals are not a guarantee of payment.

Workman's Compensation:
Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: Adjustors Name, claim status, (litigation, supportive care, claim closed, new injury), DOI, carrier, claim number and claims address. Please have this information available prior to your appointment time.

Patient Name: _____ DOB: _____

_____ Date: _____
(Patient/Guarantor Signature)

12450 N. Rancho Vistoso Blvd, • Suite #110 • Oro Valley, AZ 85755 • 520.229.2080 • www.desertskymedicine.com • FAX 520.229.2092

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby attest that I have reviewed the Notice of Privacy Practices for Desert Sky Spine & Sports Medicine. I understand that I may request a paper copy of these practices at any time. I understand that Desert Sky Spine & Sports Medicine makes every attempt at compliance with the Healthcare Information Portability and Accountability Act (HIPAA).

_____ _____

Signature Printed Name

_____

Date

DESERT SKY SPINE & SPORTS MEDICINE

NOTICE OF PRIVACY PRACTICES

Desert Sky Spine & Sports Medicine is committed to protecting the confidentiality of information about you, and is required by law to do so. This notice describes how we may use information about you within our practice and how we may disclose it to others outside our practice.

Treatment: Desert Sky Spine & Sports Medicine may use information about you to provide you with medical services and supplies. We may also disclose information about you to others that need that information to treat you, including doctors, physician assistants, nurses, technicians, medical assistants, and others involved in your care. We may also disclose your information to hospitals and surgery centers where you may be receiving treatment.

Family Members & Others involved in your care: Desert Sky may disclose information about you to a family member or friend who is involved in your medical care. If you do not want us to disclose information about you to family members or others, you must notify one of the staff.

Payment: Desert Sky may use and disclose information about you to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may request to see parts of your medical record before they will pay us for your visit.

Health Care Operations: Desert Sky may use and disclose information about you if it is necessary to improve the quality of care we provide to patients or to run the health care operations. We may use information about you to conduct quality improvement activities, to obtain audit, accounting or legal services. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Required By Law: Federal and state laws do NOT require patient consent to disclose information which is REQUIRED to be reported. For instance, we are required to report child abuse and neglect, etc. Public policy has determined that these types of needs outweigh the patient's right to privacy. Desert Sky is also required to give information to the state workers' compensation program for work-related injuries.

Public Health: Desert Sky may also report certain medical information for public health purposes. For instance, we are required by law to report certain communicable diseases to the State. We also may need to report patient problems with medications or medical products to the manufacturer and to the FDA, or may notify patients of recalls of products they are using.

Public Safety: Desert Sky may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials or to the court in response to a search warrant or other court order. We may also disclose medical information to assist law enforcement officials in identifying or locating a person or to prosecute a crime of violence. We may

also disclose information about you to law enforcement officials and others to prevent a serious threat to health or safety.

Information with additional protection: Certain types of medical information may have additional protection under State or Federal law. For instance, medical information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, may be treated differently than other types of medical information. For these types of information, Desert Sky may obtain your authorization to release this information except as required by law.

Your Rights

1. You have the right to look at information about you and to get a copy of that information. This includes your medical record, your billing record, and the other records we use to make decisions about your care. If you request a copy of your information, we may charge you for our costs to copy the information. We will tell you what this copying will cost. You can look at your record at no cost. The law requires us to keep the original record.
2. If you see information about you and believe that some of the information is incorrect or incomplete, you may ask us to amend your record.
3. You have the right to request us not to use or disclose information about you to treat you, to seek payment for care, or to operate the health care system. We are not required to agree to your request, but if we do agree, we will comply with that agreement unless that information is necessary to provide you emergency treatment.
4. You have the right to request us to communicate with you in a way that you feel is more confidential. We will accommodate reasonable requests including alternative addresses or alternative means. For example, you can ask us not to call your home, but to communicate only by mail. You can ask to speak with your health care providers in private, outside the presence of other patients.
5. You have a right to a paper copy of this Notice at any time. We reserve the right to change this Notice. If we do change these practices, we will provide a revised Notice of Privacy Practices.