RAAM SAMBANDAM, MD
BOARD CERTIFIED NEUROLOGIST

SYNAPSE
NEUROLOGY

BILLING & HEALTH INSURANCE POLICES

CANCELLATION POLICY - Our office has a cancellation / No show policy in which you will be charged $25 for failing to cancel or reschedule your office appointment 24 hours in advance. Scheduled test EMG or EEG, will require 48 hours cancelation notice or a $100 charge will incur for failing to show or cancel. Please make every attempt to call the office to notify us of any changes or emergencies that may interfere with your scheduled appointment with us. The time scheduled for your appointment is assigned to you and you alone.

FINANCIAL OBLIGATIONS - All co-payments are due when services are rendered. Deductibles and co-insurances may also be collected at this time. Outstanding balances on your account, over 45 days, may require payment before additional services are rendered.

INSURANCE CLAIM FILING - We file your insurance claims as a courtesy to you and, in most cases, provide services in good faith, prior to getting payment. If your insurance company does not respond within 60 days from the date of filing, then the balance will be transferred to you and will become your responsibility.

PATIENT STATEMENTS - You will receive a monthly statement and payment is due upon receipt. If payment is not received, or if no response to the statement is received within 45 days, further action, including collection agency involvement may be taken.

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. implementation of HIPAA requirements officially began on April12, 2003. Many of the polices have been our practice for years. This form is a “friendly” version. A more complete text is available in the office and posted on wall.

What this is about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following polices:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open files racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc, those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes in office policy and new technology that you might find valuable or informative insurance items, and items pertaining to your clinical care such as: laboratory and diagnostic results, pathology results, among others.
3. I understand that my physician may need access to my medication history and may work in conjunction with my pharmacy and/or insurance carrier in order to provide accurate medical treatment.
4. You understand and agree to inspections to the office and review of documents which may include PHI by govern-

ment agencies or insurance payers in normal performance duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. We agree to provide patient with access to their medical records in accordance with state and federal laws.
7. We may change, add, delete, or modify and of these provisions to better serve the needs of both the patient and the practice.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
9. A fee of $1.00 per page for the first 25 pages of written material and $.25 for each additional page.
10. A $25.00 fee will be charged to complete any forms such as disability paperwork (this includes FLMA and other disability forms), parking permits, evaluation form for work forms. These forms should be completed by your primary care physician, but if you need our physician to complete, there will be a fee.
11. Our office hours are 8:00AM- 4:30 PM Mondays - Friday, except major holidays.
12. Prescription refill requests will be filled 24-48 hours upon being received. To better assist you please have your pharmacy fax a refill request directly to our office at least 1 week prior to your last dose.
13. We will try to secure authorization for needed procedures with a 7-14 turnaround time. Authorization does not guarantee payment which will be determined by eligibility at the time of procedure.
14. We want you to be aware that we will request medication history through Surescripts database in our EMR system.
15. I authorize the following people to be able to receive information regarding my medical condition:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

By my signature below, I am acknowledging my review and understanding of the above BILLING & HEALTH INSURANCE POLICIES and HIPAA INFORMATION & CONSENT on the date set forth below.

Patient Signature _____

Our staff will try to meet your needs in the best way they possibly can. We highly believe in extending respect to everyone. We ask that you extend the same courtesy to them while at our facility. Abusive patients will be asked to find care elsewhere.

NOTE: If patient is unable to sign or is a minor, please sign below:

Closest Relative of Legal Guardian's Signature _____

Witness _____

To ensure Medicare beneficiaries receive the information and help needed to understand your Medicare options and Medicare rights and protections, you may contact the Office of the Medicare Beneficiary Ombudsman.

Synapse Neurology
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