



Notice of Privacy Practices

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Individual Identifiable Health Information (IIHI). In conducting our practice, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. BY federal and state law, we must follow the terms of notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- ◆ How we may use and disclose your IIHI
- ◆ Your privacy rights in your IIHI
- ◆ Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this *Notice of Privacy Practices*. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of your current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS

NOTICE, PLEASE CONTACT:
Practice Manager @ 337-989-8795

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

1. Treatment. Our practice may use your IIHI to treat you. Additionally, we may disclose or release your IIHI to others who may assist in your care, such as your spouse, children or parents. We may disclose protected health information about you to physicians, nurses,

technicians, and other personnel who are involved in taking care of you. They may work at our office, at the hospital if you are hospitalized under our supervisors, or at another physician's office, laboratory, pharmacy, or other health care provider whom we may refer you for consultation, perform laboratory testing, to have prescriptions filled, or for other treatment purposes. For example, we would disclose your IIHI, as necessary, to a home health agency that would provide care for you. We would also disclose your IIHI to other physicians who may be treating you. For example, your IIHI may be provided to a physician to whom we referred you in order to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information to your health care diagnosis or treatment to your physician. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. 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. For example, if an insurance company needs to make a determination of eligibility or coverage for insurance benefits, review services provided to you for medical necessity, and undertake utilization review activities. An example could be, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the insurance carrier in order to receive approval for hospital admission. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

3. Health Care Operations. Our practice may use and disclose your IIHI in order to support the business activities of your physician's practice. These uses and disclosures are necessary to run our practice and make sure that all our patients receive quality care. These activities include, but are not limited to, quality assessment activities, employee review activities, training of employees, fundraising activities, study / research purposes, and conduction or arraigning for

other business activities. For example, we may disclose your IIHI to medical students that see patients at our office. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose you IIHI, as necessary, to contact you or to remind you of your appointment. We will share your IIHI with third party "business associates" that perform various activities (transcription services, electronic transmission of insurance claims, etc.) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your IIHI, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may disclose your IIHI if outside storage facilities are used. We may disclose or use your IIHI for study / research purposes. For example, a research project may involve comparing the health and recovery of certain patients who received a particular medication to those who received another kind of medicine for the same medical condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with the patient's need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process.

For a list of all other situations in which your IIHI may be shared please ask to speak with our HIPAA officer, and this information will be provided.

Complaints. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA officer of your complaint. We will not retaliate against you for filing a complaint.

FINANCIAL POLICY

We appreciate your confidence in our practice and would like to work with you to limit the rising cost of medical care. You can help a great deal by reviewing the following summary of our payment policy. This policy was implemented to reduce paperwork and

delays in payment, which in turn decrease the cost of care for everyone.

We will ask to see your insurance card at every visit to ensure there are no changes. We will also ask for a new patient information sheet to be completed every year in order to maintain accurate information in our files. Updating this information regularly will prevent incorrect billing of insurance and will also allow timely receipt of statements and/or refunds when necessary.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered. Co-payments are set by the insurance company to off-set the negotiated rate of our charges and will not be billed to the patient. All co-pay amounts must be paid at the time of visit without exception.

Deductible and coinsurance amounts will be calculated based on your insurance contracted rate and will be payable at time of visit. We will make every effort to verify your insurance benefits before or on your appointment date to ensure payment amount expected is as accurate as possible for this service. Fertility Answers accepts cash, personal check, credit, and debit cards.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments or requesting prescription renewals. We realize that people have financial difficulties and we will make every effort to accommodate our patient's needs after a financial evaluation form is completed.

RETURN CHECKS

There will be a \$25.00 charge for returned checks. Return checks must be paid in full within 10 days of notification. Checks not paid will be forwarded to the collection agency for final collection and no further checks will be accepted for payment.

INSURANCE

We bill participating insurance companies as a courtesy to you. Please verify your insurance participates with our practice prior to your appointment. You are expected to pay your deductible and co-payments at the time of service. **If we have not received payment from your insurance company within 45 days of the date of service, you will be**

expected to pay the balance in full. You are responsible for all charges.

If you need assistance or have questions, please contact collections coordinator, between 8:00 AM and 4:30 PM, Monday through Thursday and 8:00 AM to Noon on Friday s, at 337-989-8795.

REFUNDS

Overpayments less than \$100.00 will be refunded upon request to the responsible party within 30 days. Refunds over \$100.00 will be processed and mailed to responsible party without a prior request.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge \$50.00 for missed or late canceled appointments. Two no-shows of scheduled appointments will result in discharge from the practice.

I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections. I agree to be financially responsible for charges incurred. I authorize payment of medical benefits directly to the physician or supplier of treatment. I understand and agree that I am ultimately responsible for my account of any professional services rendered, regardless of my insurance status. I agree to pay for the services rendered even though my insurance company may determine that the services are not necessary or not covered. I agree to be responsible for any billing charges, finance charges, collection fees, or attorney fees assessed to my account should it become delinquent.