Endocrinology Associates, Inc.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Endocrinology Associates, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Endocrinology Associates, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Endocrinology Associates, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Endocrinology Associates, Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept or decline the terms of this consent.

Patient/Guardian Printed Name

Patient's Signature — Date

Patient refused to sign-Witness — Date

Revocation:

I hereby revoke the consent given above:

Patient/Guardian Printed Name

Patient/Guardian Signature — Date

Consent for assignment of benefits: I consent to assign all payments for these services to Endocrinology Associates, Inc. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I am responsible for all charges that are incurred.

Patient/Guardian Signature — Date

FOR OFFICE USE ONLY

- [x] Consent received by asda on .
- [x] Consent refused by patient, and treatment refused as permitted.
- [x] Consent added to the patient's medical record on .

Elena A. Christofides, MD, FACE
ENDOCRINOLOGY ASSOCIATES, INC.
ENDOCRINOLOGY, DIABETES AND METABOLISM

Board Certified

Dear Patient:
We sincerely appreciate that you have elected to receive health care services from us. We will do everything possible to ensure that you are completely satisfied with the health care services you receive. In exchange, we ask that you satisfy the following obligations [please read carefully and initial beside each item]:

Insurance Plans

_____ We participate in numerous government and commercial health insurance plans and programs. However, we may not participate in your health insurance plan. You are solely responsible for ascertaining your coverage benefits PRIOR to your first appointment.

_____ If we do not participate with your health insurance plan, we will not file your claim. You will be provided with a detailed receipt at the time of payment that you can submit to your health insurance plan for reimbursement.

_____ If required by your health insurance plan, you must obtain any required referral(s) from your primary care physician or other applicable provider.

Payments

_____ All payments are due in full for the applicable amount(s) at the time of service (a) for any co-insurance, deductibles, or other applicable cost sharing amounts, and/or (b) if we do not participate with your health insurance plan.

_____ If we participate with your insurance plan, you must pay all balances associated with your account within 90 days of service. If you are unable to make timely payments, you must promptly contact our billing administrator.

_____ You may pay by cash, check or personal credit card. We are unable to process CareCredit cards.

_____ If you want to pay over the phone with a credit card, we will charge a 5% administrative fee due to our credit card processing service.

Administrative Fees

_____ You may be charged administrative fees for the following:

- Returned Checks (the greater of $45 per occurrence or the applicable fees charged by our financial institution).
- Completion of Forms (i.e., disability or FML paperwork) (fees calculated on actual employee time and expense)
- Copying of Medical Records (fees will be determined consistent with applicable law)
- Failure to comply with the Missed Appointment and Cancellation Policy.

Prescription Management

_____ For your health and safety, we will not renew or order refills of your prescriptions if you have not received a face-to-face visit with our provider(s) in more than twelve (12) months.

Personal Information

_____ Please promptly inform us of any change in your personal information, including health insurance plan, address or telephone.

72 West Third Ave
Columbus, Ohio 43201
TEL 614-453-9999 FAX 614-453-9998
www.endocrinology-associates.com

Elena A. Christofides, MD, FACE
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☐ We may periodically send notices (statements, appointment reminders, etc.) to you using the contact information we have on file. If you do not respond to three (3) consecutive notices, we may dismiss from our practice.

Signature Page:

Patient Signature	Date Reviewed

Issued: 5/5/15

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MISSED APPOINTMENT AND CANCELLATION POLICY

We are committed to providing quality health care services in a timely manner. To help us fulfill this commitment, this policy is intended to prevent missed appointments and provide a process to cancel an appointment if necessary.

Missed Appointment

A missed appointment is an appointment for which you (a) arrive at our office more than fifteen minutes after the scheduled time, OR (b) fail to properly cancel in accordance with this policy. We may charge you a fee, in the amount of $50.00, for each missed appointment. You must pay a missed appointment fee in full prior to your next appointment. We may also dismiss you from our practice for missing more than two (2) scheduled appointments in a twelve (12) month period.

Cancellation

If canceling your appointment is necessary, we require that you call our office at least twenty-four (24) hours in advance. If you do not reach the receptionist, you have to call back or email the office at reception@endocrinology-associates.com.

Emergencies

We understand that situations or emergencies arise that prevent you from arriving to an appointment on-time or cancelling your appointment in accordance with this policy. We will consider these situations on a case by case basis.

Patient Signature	Date

Issued: 11/25/2019

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