Apex MD

5310 Twin Hickory Rd, Suite A, Glen Allen, VA 23059
Tel: 804.273.0010 • Fax: 804.273.0049
admin@apex-MD.com • www.apex-MD.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____Date of Birth: _____/_____/_____
mm dd yyyy

Social security number: _____

Phone _____ Address _____

Legal Guardian name: _____ Relationship to Patient: _____

I request a copy or summary of the following medical records:

☐ Complete Medical Record* ☐ Immunization Record* ☐ Lab Report(s) ☐ X-ray Reports
☐ Electrocardiogram ☐ Allergy Records ☐ Surgical Procedures ☐ Other _____

Required if transferring records to Apex MD

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, Drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

For dates of service from ____/____/____ to ____/____/____

Purpose of Release:

☐ Transfer of care ☐ Moving out of area ☐ Specialist consultation ☐ Legal ☐ Personal
☐ Insurance Claim ☐ Workers' Compensation Claim ☐ Pharmacy/prescription records/Other _____

☐ Request to transfer records **TO Apex MD** from the office listed below

☐ Request to transfer records **FROM Apex MD** to the office listed below

- Please allow 15 days for processing. Incomplete information will delay processing.

Office Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that such a revocation will not apply to information that has already been released in response to this authorization.

Signature: _____
Patient or Legal Guardian

Disclosures and Consents

Patients or legal guardians for minor child MUST sign and date all paragraphs below before medical care can be rendered.

PATIENT INFORMATION	
Legal Name: (First) (Middle) (Last)	Date of Birth:

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Apex MD, or the providers individually, for services rendered to my dependents or to me by the physician or the clinician under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. **I understand and agree that I will be responsible for any co-payments, co-insurance, deductibles or balances due that are my responsibility for payment either at the time of service or after being notified that Apex MD is unable to collect from my insurance carrier for whatever reason.**

FINANCIAL RESPONSIBILITY:
I certify that I have received, read and understood Apex MD Patient Financial disclosure. I also understand that I am ultimately responsible for the charges incurred by me or by my child/children as their legal parent or guardian. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or attorney for collections, that I undersigned shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from the physician care of Apex MD. I am responsible for the entire charge of any service that I have consented to receive.

For Self-Pay patients, I also understand that I am responsible for all services rendered to my dependents or myself at the time of service.

MEDICARE INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my medical records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Apex MD, LLC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of Apex MD Notice of Privacy Practices and authorize the release. I hereby authorize Apex MD, LLC or the physician individually to release any of mine or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill for labs, x-ray, or other diagnostic services from another facility for which I am financially responsible for any co-payment, co-insurance, deductible or balance due for these services if they are not reimbursed by my insurance for whatever reason. I am responsible for any fees for labs that are not covered for any reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing and treatment for me or my dependents as directed by my physician/physician-extender or his or her designee at Apex MD.LLC. I understand the services may include lab tests, screening tests, diagnostic tests, and routine exams. I understand that no promises have been made to me about the results of any treatment or services.

PATIENT SIGNATURE: _____ **DATE:** _____
(or Legal Guardian, for minor patient)

PRINT NAME: _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)

GUARANTOR NAME: _____

APEX MD LLC
5310 Twin Hickory Road
Suite A
Glen Allen VA 23059
Phone: (804)273-0010
Fax: (804) 273-0049
www.Apex-MD.com

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Due to the Privacy Act please list names of anyone you would like to have access to your medical information. Please understand that without your consent, we will deny any request for information to family members. Only the names listed below will be given any information regarding your medical condition.

I hereby authorize APEX MD LLC, its staff and providers to disclose my protected health information to the following representative:

Representative Full Name:

Relation to patient:

Phone:

This authorization is **valid indefinitely unless cancelled by the patient for future release.**

Signature:

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice describes our privacy practices.

Our Pledge Regarding Health Information
We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements.
We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI
The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to physicians, nurses, technicians, health students, or other personnel who are involved in taking care of you. 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.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment before you receive it so that we can obtain prior approval or determine if your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for the operation of our health care practice. These uses and disclosures are necessary to run our practice and to make sure that all our patients receive quality care.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different address to contact you for this purpose.

Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes. The Quality Assurance Committee of the Board of Directors must approve all

research projects. This committee evaluates all potential projects and selects those that will be of direct or indirect benefit to our patients and/or community.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank or to organizations that handle organ procurement or organ, eye, or tissue transplantation, as necessary to facilitate organ or tissue donation and transplantation.

As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law enforcement officials.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated or discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans' Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following:

- The prevention or control of disease, injury, or disability
- The reporting of births and deaths
- The reporting of child abuse or neglect
- The reporting of reactions to medications or problems with products
- The notification of people about recalls of products they may be using
- The notification of a person or organization required to receive information on Food and Drug Administration–regulated products
- The notification of a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- The notification of the appropriate government authority, if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law)

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. Such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- In reporting certain injuries, as required by law: gunshot wounds, burns, dog bites, and injuries to perpetrators of crime
- In response to a court order, subpoena, warrant, summons, or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person (name and address, date of birth or place of birth, social security number, blood type or Rh factor, type of injury, date and time of treatment and/or death, if applicable, and a description of distinguishing physical characteristics)
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our facility
- In emergency circumstances to report a crime; the location of a crime or victims; or the identity, description, or location of a person who committed a crime

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner or health examiner. To identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

Your Rights Regarding Health Information About You
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information such as health and billing records.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. .

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.
Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. You can ask that we only contact you at work or by mail to a post office box.

Right to a Copy of This Notice: You have the right to obtain a copy of this notice at any time via electronic or paper means.

Changes to This Notice
We reserve the right to change this notice as effective for health information we already have about you as well as any information we receive in the future.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services in Washington, DC. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Other Uses of Health Information
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission.

Acknowledgment of Receipt of This Notice
We will request that you sign a separate form acknowledging that you have read the notice.

PATIENT FINANCIAL POLICY

Effective May 1, 2012

Thank you for choosing Apex MD as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy:

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE.

We accept: Checks and Credit Cards. We avoid cash, if possible.

It is the policy of APEX-MD to help keep your health care costs as low as possible. Please help us in the following ways:

- Always bring your current health insurance card to the office. Please notify us at time of check-in of any changes in insurance, address, telephone or family status.
- Please pay your co-pay or deductible balance and co-insurance amount at the time of service.
- You will be expected to pay in full if:
  - You do not have insurance,
  - Apex MD does not participate with your health plan,
  - You are unable to present a valid member identification card from your insurance carrier at your visit, or
  - We are unable to verify your insurance coverage.

You should receive a bill for any other patient responsibility within 30 days; and/or an explanation of benefits (EOB or EOP) from your insurance company. If you fail to receive an EOB or EOP from your plan within 45 days of treatment, we suggest you contact your insurance plan to determine benefits, as they may not have made payment. Payment not received in 60 days may be transitioned to patient responsibility and you may be required to make other payment arrangements.

INSURANCE: Your insurance policy is a contract between you and your insurance company. In the event that we do accept assignment of benefits please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for these charges. It is your responsibility to:

- Ensure our providers actively participate with your insurance carrier.
- Know your benefit coverage, as well as your dependents, prior to receiving services.
- Ensure that all pre-approval requirements are met to avoid denials or out-of network benefits.

Please remember that we must receive your billing information at the time of each visit in order to meet claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.

Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

To summarize, your financial responsibility retains to:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pended claims due to lack of patient and/or guarantor information
- Non-Insurance and/or out-of-network benefits

CO-PAY, COINSURANCE: **We are required by our insurance contracts to collect ALL co-pays and other patient responsible amounts, at the time of service**. We may request payment of any previous balance due prior to be seen by the physician.

DEDUCTIBLES: **If you have NOT met your deductible – we will collect up to $100 applicable towards your deductible at check in** – this is an

estimate only – you may receive a statement with additional balances after your visit.

SELF-PAY PATIENTS: **Self-Pay patients are required to make a deposit of $125 at the time of service during check-in.** If additional charges are accrued, you must pay by the charges before leaving the office.

OUT OF NETWORK: **Out of network patients are required to make a $125 deposit upon check in at time of service.** Any additional balance due after receiving a statement will be patient responsibility.

RETURNED CHECKS: There is a fee (currently $35.00) for any checks returned by the bank.

MISSED APPOINTMENTS: **Unless canceled at least 24 hours in advance, our policy is to charge $25.00 for missed appointments.** We will not file, nor will insurance plans pay for this charge, so please help us serve you better by keeping, or canceling in advance, scheduled appointments.

AFTER HOURS TELEPHONE CONSULTATION: Apex MD is a primary care which is open throughout the year and has extended hours in weekdays. You are welcomed to walk in during business hours. We recommended you to use our services during office hours to avoid after hour consultation.

COLLECTIONS: Failure to pay account balance within 30 days from initial billing may result in interest charges up to maximum legal amount allowed by law. Any past due balance not paid will be turned over to a collection agency after 30 days. Any charges and fees resulting from this action, including collecting agency fees, will be added to your account balances and will be your responsibility. In the event that the bill remains unpaid and litigation ensues for collection of sums due, this office shall be entitled to reasonable attorney fees and court cost.

LAB/X-RAY/DIAGNOSTIC SERVICES: You may receive a separate bill for medical care includes lab, x-ray, or other diagnostic services from another facility. You are financially responsible for any co-pay or balance due for these services if they are not reimbursed by your insurance.

STATEMENTS: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payment or credits applied to your account during the month.

PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE: Unless arrangements are made in advance, we will collect payment at your visit. Your choice is to pay by cash, check, or credit/debit card on the day that treatment is given.

INSURANCE RELEASE: You understand that your health plan may not be liable for service rendered if any of the following conditions apply:

- You have a pre-existing condition or other diagnosis that may not be covered by your plan;
- Apex MD does not participate in your health plan;
- You have not met the deductible under your health plan contract;
- Well child check-up, immunizations, adult or sports physicals, as well as other routine services, may not be covered by some insurance plans.

MINORS: In case of minors, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges.

ON-THE-JOB INJURIES/ACCIDENTS: If the reason for your visit is an accident or injury while on the job, please know that we will submit the bill directly to your employer or your employer's workers' compensation carrier – the bill will not be covered unless your employer files a claim to the carrier – it will remain your responsibility until a valid claim is filed by your employer.

COPIES AND TRANSFER OF RECORDS: All past due amounts will be collected before medical records are copied or transferred. A nominal fee is assessed to cover copy costs.

EFFECTIVE DATES: Once you have signed this agreement, you agree to all of the terms and conditions

contained herein for this and any future visits, and the agreement will be in full force and effect.

INSURANCE OPT OUT: A patient may choose to opt out of insurance to be considered as self pay during a visit. All fees are payable in full at time of service. This will be considered patient responsibility and liability.

Signature:_____

Patient or Legal Guardian