Codella FAMILY PRACTICE

Welcome To Codella Family Practice

We look forward to getting to know you and the members of your family. We are committed to providing you not only high quality medical care for years to come, but also a level of service that respects your lifestyle needs. We hope you will explore our Web site at www.codellafamilypractice.com to learn all the ways we do this, from our range of services, our team of dedicated providers, convenient locations, and the ease of access to health information and medical care.

Healthcare is most successful when patients and providers work as partners. We hope you share our expectations for what each of us needs to do, to provide you with the best healthcare.

Patient Compact

Principles for Partnership

As your healthcare partner we pledge to:

- Include you as a member of the team, treat you with respect, honesty and compassion
- Always tell you the truth
- Include your family or advocate when you would like us to
- Hold ourselves to the highest quality and safety standards
- Be responsive and timely with our care and information to you
- Help you to set goals for your healthcare and treatment plans
- Listen to you and answer your questions
- Provide information to you in a way you can understand
- Respect your right to your own medical information
- Respect your privacy and the privacy of your medical information
- Communicate openly about benefits and risks associated with any treatments
- Provide you with information to help you make informed decisions about your care and treatment options
- Work with you, and other partners who treat you, in the coordination of your care

As a patient I pledge to:

- Be a responsible and active member of my healthcare team
- Treat you with respect, honesty and consideration
- Always tell you the truth
- Respect the commitment you have made to healthcare and healing
- Give you the information that you need to treat me
- Learn all that I can about my condition
- Participate in decisions about my care
- Understand my care plan to the best of my ability
- Tell you what medications I am taking
- Ask questions when I do not understand and until I do understand
- Communicate any problems I have with the plan for my care
- Tell you if something about my health changes
- Tell you if I have trouble reading
- Let you know if I have family, friends or an advocate to help me with my healthcare

Codella FAMILY PRACTICE

NAME:_____

Last First Middle

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____ SEX:_____ MARITAL STATUS: S M D W

PHONE (HOME)_____ (CELL)_____

PLEASE PROVIDE EMAIL TO JOIN THE PATIENT PORTAL

EMAIL:_____ SOCIAL SECURITY:_____

PHARMACY:_____ PHARM PHONE:_____

PHARM ADDRESS:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

ADDRESS:_____ CITY:_____ STATE:___

PHONE, HOME:_____ CELL:_____ ZIP:_____

INSURANCE INFORMATION:_____

NAME OF INSURED:_____ RELATIONSHIP TO PT:_____

POLICY #:_____ GROUP #_____

SECONDARY INSURANCE:_____

NAME OF INSURED:_____ RELATIONSHIP TO PT:_____

POLICY #:_____ GROUP #_____

Signature:_____ Date:_____

Codella FAMILY PRACTICE

PATIENT NAME:_____

PLEASE PRINT

GOVERNMENT MANDATED QUESTIONS:

RACE: __ White __Black/African American __ American Indian/Alaskan Native

__ Asian __ Native Hawaiian/Other Pacific Islander __Other __ Decline To Answer

ETHNICITY: __ Spanish/Hispanic Origin __ Not Of Hispanic Origin __ Declined/Unknown

In order to comply with federal regulations regarding your privacy, we ask that you complete the following. Do you authorize this office to leave information via:

Home Phone ___YES ___NO Cell Phone ___YES ___NO

Email ___YES ___NO With another person ___YES ___NO (see below)

If you authorize us to discuss information with another person, please provide their information below. Without your written permission, we are UNABLE to discuss any information with anyone.

NAME RELATIONSHIP CONTACT NUMBER

ASSIGNMENT OF BENEFITS:

I irrevocably assign to Codella Family Practice all my rights and benefits under any insurance contracts for payment for services rendered to me by Codella Family Practice. I am aware that I am responsible for payment of services rendered to me that are not covered by my insurance plan (including if I fail to change my primary care physician to Dr. Vincent Codella). This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

NAME:_____ (please print)

SIGNATURE:_____ DATE:_____

Codella FAMILY PRACTICE

Office Policies

In an effort to provide the highest quality care to you, and to ensure an excellent physician-patient relationship, I request that you review the below list of office policies.

1. Please arrive by your scheduled time. In an effort to reduce wait time, any patient more than 20 minutes late for their appointment, may be asked to reschedule to avoid setting back the physician's schedule.
2. Upon arrival, please check-in at the front desk. It is the patient's responsibility to inform the office of any changes to your address, contact information, insurance policy etc. You must present your current insurance card and driver's license at each visit. Additionally, each calendar year, you will need to fill out new registration forms in order to update our files.
3. The patient is responsible to select Dr. Codella as the Primary Care Physician *prior* to the patient appointment. If you do not do so, you will be asked to reschedule your appointment and will not be able to be seen until you select Dr. Codella as your Primary Care Physician, as it is required for your appointment.
4. Dr. Codella is available to all patients after hours for emergency care (as well as typical "off hours", such as weekends and holidays). In the event that Dr. Codella is not "on call", there will be another physician "on call" and available to patients of the practice.
5. Co-payments are collected *upon arrival*, prior to your visit with the physician. Your insurance company mandates that all patients be charged a copay.
6. Also, it is the responsibility of the patient to understand if it is necessary for you to obtain a referral or authorization *prior* to specialists visits or diagnostic testing. We strive to stay current with insurance requirements but the polices change often and without notice, so you are ultimately responsible (although we assist to the fullest extent possible). Please note that many insurance companies require up to 14 business days for Radiology and medication authorizations.
7. If you need a referral, please allow up to 5 business days prior to picking it up in the office. (Many referrals are sent electronically, and may not need to be picked up from the office). If Codella Family Practice orders an emergency test, we will provide an emergency referral.
8. In the event that a patient goes to a specialist appointment *without* a referral, Codella Family Practice is *not* responsible for you needing to reschedule that appointment or any associated fees.
9. If a Specialist orders a study, it is their responsibility to obtain authorization.
10. The billing department can be reached directly at 908-662-5148.
11. Please be advised that Medicare and/or your private health insurance carrier may not cover certain procedures or services that your doctor deems necessary for the complete evaluation and management of your care. This may include various injections, diagnostics tests, etc. Please note that you may be responsible for any balance not paid by your insurance company.
12. In an attempt to maintain a high quality of service to all patients, and to improve staff interactions with patients on the telephone, calls are recorded.
13. Forms will be completed at the time of your visit. Any forms dropped off after your appointment, will incur a $10.00 processing fee. Forms will typically be ready for pick-up in 5 business days.
14. Any returned checks will be assessed a $25 fee, in addition to any bank fees charged to Codella Family Practice. If a patient provides payment by a check that is returned for insufficient funds more than 1 time, all further payments must be made by cash or credit card.
15. There is a $25 NO SHOW fee for all visits not cancelled with 24 hours or more notice.
16. After 2 NO SHOW's, Codella Family Practice has the right to dismiss you from the practice.
17. There is a $10.00 processing fee for all requests of Medical Records. In addition, there is a $1.00 charge *per page*, up to a maximum of $100.00 for the entire record. The processing time for this request is 7 business days.

I have read and agree to these terms: _____

Print

_____

Sign and date

If you have any questions, please let me know when I see you during the visit, or feel free to contact me at a later time.

Thank you,

Dr. V. Codella

As of 09/01/2017

Codella FAMILY PRACTICE

PATIENT RESPONSIBILITY

FOR FOLLOW-UP CARE PLEDGE

I, _____ (print last name), _____ (print first name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy and treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

I have read and agree to these terms: _____

Print

_____

Sign and date

Codella FAMILY PRACTICE

Patient Financial Policy Agreement

- I will present proof of Insurance coverage at every visit.
- I understand it is my responsibility to be educated about the benefits and limitations of my Insurance policy.
- I understand my insurance policy is a contract between me and my insurance company. In the event they do not pay for services rendered to me which may include vaccinations, injections and durable medical goods, I am financially responsible for payment for those services.
- If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collections agency, you agree to pay all the collection costs which are incurred.
- I understand that my account may be sent to a professional collection agency if payment is not rendered within 90 days from the billing date and in that event my relationship with Codella Family Practice may be terminated.
- I understand that if I disagree with any charges or would like to request an adjustment be made on my invoice or claim, I must contact the billing office in writing within 30 days of the billing date.
- I understand that it is my responsibility to provide Codella Family Practice with any information necessary to be paid for services rendered to me or anyone covered under my insurance policy or I will be responsible and will pay the balance in full.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Codella Family Practice to apply for benefits on my behalf for covered services rendered by my family physician, or by his/her order. I request that payment form my insurance company be made directly to Codella Family Practice (or to the party who accepts assignment),

I certify that the information I have reported with regard to my insurance coverage is correct. I agree and accept the terms of the Codella Family Practice Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing,

Date _____ **Signature (Patient/Gaurdian)** _____

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

I understand as part of my health care, **Codella Family Practice**, originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that his information serves as:

- A basis for planning my care and treatment
- A means of communication among the 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 thirdg party payor can verify that services billed were actually provided,

and I understand that I have the following rights and privileges as:

- The right to review the notice prior to signing this consent.

I understand that Codella Family Practice 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 Codella Family Practice 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. 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 / decline the terms of this consent (please circle one)
I have been presented with and understand Codella Family Practice Notice of Privacy Policy as:

_____ _____

Patient's Signature **Date**

Patient's **PRINTED NAME** _____

If not signed by patient, please indicate your relationship to the patient (parent, spouse) _____

FOR OFFICE STAFF ONLY

( ) Consent received by _____ on _____

( ) Consent refused by patient, and treatment refused as permitted

Codella FAMILY PRACTICE

ACKNOWLEDGEMENT OF RECEIPT

OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I had read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Patient Name (Please Print) Date

_____

Parent of Authorized Representative (if Applicable)

_____

Signature

NOTICE OF PRIVACY PRACTICES

Codella Family Practice

Effective Date: August 1, 2013

SUMMARY

WHAT IS THIS NOTICE FOR? This Notice of Privacy Practices (Notice) describes how Codella Family Practice (We or Us) may use and disclose your medical information that we maintain and how you can get access to this information.

WHO ARE WE? Codella Family Practiceis a Family Practice which consists of all employed doctors, nurses, employees and other healthcare professionals. This Notice applies to these individuals as well as all services that are provided to you at our facility/any of our facilities.

WHY DO YOU NEED THIS NOTICE? The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, places certain obligations upon us with regard to how we may use and disclose your ***personal health information*** (PHI). Your PHI includes medical information about you such as your medical record and the care and services you have received. We are committed to **maintaining the privacy** of your PHI. When we need to use or disclose it, we will comply with the full terms of this Notice. Anytime we are permitted to or required to share your PHI with others, we only provide the **minimum** amount of data **necessary** to respond to the need or request unless otherwise permitted by law.

WHEN CAN WE USE/DISCLOSE YOUR PHI? There are certain uses and disclosures of your PHI that we may undertake **without your written or other authorization.** These uses and disclosures may be for purposes such as to provide you with treatment, obtain payment for services we have provided, and other health care operations (such as administration, quality improvement, cost studies and other activities designed to improve the care we provide to all our patients). Some other examples include: PHI made known to your relatives, close friends, or caregivers, public health activities and officials, reporting of abuse or neglect as may be required by law, health oversight activities, judicial and administrative proceedings, law enforcement officials, workers' compensation, and other individuals and activities as set forth in this Notice. Individuals who may have access to your information **without your written or other authorization** may include doctors, nurses, health care students, and other hospital staff.

WE MUST OBTAIN YOUR WRITTEN AUTHORIZATION FOR ANY USE OR DISCLOSURE NOT SET FORTH IN THIS NOTICE. You may revoke this authorization AT ANY TIME. In addition to obtaining your written authorization for uses or disclosures not described in this Notice, we generally will also need to seek your written authorization or approval prior to disclosing the following information:

- HIV/AIDS related information
- Sexually transmitted disease information
- Tuberculosis
- Psychotherapy notes
- Mental health information
- Drug & alcohol information
- Genetic information

- Any information where you, if a minor, sought emancipated treatment (e.g., care related to your pregnancy or child, sexually transmitted diseases, etc)

We will also seek your **written authorization** for any "marketing" activities we may conduct or where we would receive money for providing a third party with your PHI.

WHAT RIGHTS DO YOU HAVE FOR YOUR PHI? You have the right to ask us to limit certain uses and disclosures of your PHI. We will consider ALL requests but may not be *required* to agree to your requested limitations. You also have the right to inspect and receive copies of your PHI, the right to request a change or amendment be made to your PHI, the right to an accounting (a list) of certain disclosures of your PHI, and the right to revoke any authorization you may have made to the extent we have not yet relied upon it. You also have the right to receive a paper copy of this Notice at any time.

CAN WE CHANGE THIS NOTICE? We may change this Notice **at any time.** The revised Notice will apply to all PHI that we maintain. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised Notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice on our web site **Codella Family Practice**. You may obtain the new Notice in hard copy as well from our Privacy Office.

ADDITIONAL INFORMATION/COMPLAINTS. You may contact our Privacy Office if you wish any additional information or have questions concerning this Notice or your PHI. If you feel that your privacy rights have been violated, you may also contact our Privacy Office OR file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. **We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights.**

THE ABOVE IS ONLY A SUMMARY OF THE RIGHTS AND OBLIGATIONS WITHIN THIS NOTICE.
PLEASE READ CAREFULLY THE ENTIRE NOTICE THAT FOLLOWS.
WE WELCOME ANY QUESTIONS YOU MAY HAVE.