PATIENT FINANCIAL RESPONSIBILITES
AND BILLING INFORMATION

Thank you for choosing the Wakulla Urgent Care & Diagnostic Center as your provider of health care services. We believe it is important that we communicate our patient financial policies with you. Our office staff will be happy to help you with any questions you may have.

As a Patient/ Parent / Guardian, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance or co-payments and other plan provisions that may impact your financial responsibility.
While you may have insurance coverage to pay your medical bills, you are ultimately responsible for all changes. You are responsible to notify our office staff of your insurance and to provide all the necessary information about your insurance plan.
You are responsible for co-payments, co-insurance or deductibles. These payments are due and payable at each appointment when requested. Wakulla Urgent Care & Diagnostics Center is required to collect your co-payment at the time of service because Wakulla Urgent Care & Diagnostics Center is contracted and obligated to do so by the insurance company as a part of its agreement to extend service to their members.
If you are utilizing your insurance benefits, you agree to assign payment from your health plan to the provider. It is your duty to notify this office if you have had a change in insurance.
It is also your duty to ensure that the physician you are seeing is on file as your Primary Care Provider with the insurance, if these do not match you will be responsible for charges incurred because insurance will not pay.
If your account has an outstanding balance, you will be asked to pay all or a portion of the balance before being seen.

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

NOTICE OF PRIVACY PRACTICES AND PATIENTS' RIGHTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND YOUR RIGHTS AS A PATIENT. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices, effective November 1, 2011, describes how we may use and disclose your protected health information for treatment, payment or healthcare operations, and for other purposes that are required or permitted by law. It also provides your rights to access and control your protected health information. Protected health information (PHI) is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition, and related health care services.

We reserve our right to revise, make new policies, or change the terms of this notice. Any revisions to our privacy practices will apply to all protected health information that we maintain at that time. We will post a notice of any revised practices in a prominent place on our premises.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

All departments and offices comprising our practice, will use, share and disclose your protected health information as necessary for quality health care, treatment, payment, and our health care operations. We will not ask you to sign a consent form for uses and disclosures that are allowed, as described in this notice. Otherwise, your written consent will be maintained on file; and you have the right to revoke your consent, unless we have taken action in reliance on your authorization. Your consent to and acceptance of our services will mean that you have consented to our use and disclosure of your protected health information, as provided in this notice.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including your surgical procedures, drug study participation and/or eligibility, and all in-office ancillary healthcare services provided by our organization. This also includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We will also disclose your protected health information to other outside physicians who may be treating you when we have the necessary permission from you to disclose your protected health information.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. 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, such as making a determination of eligibility or coverage for insurance benefits.

Health Care Operations. We will use and disclose your protected health information as necessary to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, marketing activities, drug study/recruitment activities, clinical improvement, professional peer review, business management, accreditation/licensing, and conducting or arranging for other practice-related business activities.
Additionally, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. When your physician or other staff member is ready to see you, we may call you by name while you are in the waiting area. We may use or disclose your protected health information, as necessary, to contact you for appointment or other reminders or notifications.

Business Associates. At times it may be necessary for us to provide your protected health information to certain outside persons or organizations that assist us with our health care operations, such as auditing, accreditation, billing, legal services, etc. These business associates are required to properly safeguard the privacy of your information. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Appointments and Services. Our office and associated health care operations may contact you to provide appointment reminders or information about treatment alternatives, drug studies, or other health-related benefits and services that may be of interest to you.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may further use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In such case, only the protected health information that is relevant to your health care will be disclosed.

Family and Friends. With your written approval, and using our best judgment, your protected health information may be disclosed to designated family, friends, and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies. We may use and disclose your protected health information in an emergency treatment situation. Should such an emergency arise, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If our physician is required by law to provide treatment and we have attempted, but have been unable, to obtain your consent, we may still use or disclose your protected health information in rendering treatment to you.

Communication Barriers. We may use and disclose your protected health information if your physician attempts to obtain your consent but is unable to do so due to substantial communication barriers, and the physician determines, using professional judgment, that you intend to consent to such use or disclosure under the circumstances.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations, without your consent or authorization:

Required by Law/Public Health. Releases required by law and/or public health activities (e.g. disease, injury, birth/death reporting) and public health investigations;

Abuse or Neglect. Releases required for suspected child abuse or neglect, or if you are suspected of being a victim of abuse, neglect, or domestic violence;

Food and Drug Administration. Releases to the Food and Drug Administration for reporting adverse events, product defects, or for product recalls;

Employment. Releases to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;

Regulatory Agencies. Releases legally required to a government oversight agency conducting audits, investigations, or civil/criminal proceedings;

Legal Proceedings. Releases pursuant to a court order, administrative ordered subpoena or discovery request; in most cases you will have notice of such releases;

Law Enforcement. Releases to law enforcement as legally required for reporting wounds, injuries, and crimes;

Coroners and Funeral Directors. Releases to coroners and/or funeral directors according to applicable laws;

Organ Donation. Releases for organ/tissue donation or transplantation, according to your written instructions, or other legal directives;

Military Requirements. Releases for military requirements, armed forces services, or if necessary for national security or intelligence activities;

Workers' Compensation. Releases to workers' compensation agencies, as applicable to your workers' compensation benefit determinations;

Research. Releases to researchers when their research has been approved by an institutional review board; and

Inmates. Releases if you are an inmate of a correctional facility and we created or received your protected health information in the course of providing care to you.

PATIENTS' RIGHTS NOTIFICATION

You are entitled to certain rights that you may exercise as described below.

Access to Protected Health Information. You have the right to copy and/or inspect much of your protected health information that we retain on your behalf, and that is contained in a designated record set, for as long as we maintain such protected health information. A "designated record set" contains medical and billing records and any other records that your physician and our office used for making decisions about you. Your request to access your protected health information must in writing, dated, and signed by you or your legal representative. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action, and protected health information that is subject to law that prohibits such access. In some circumstances, you may have a right to have reviewed any decision denying your request for such protected health information.

Amendments to Protected Health Information. You have the right to request in writing that your protected health information that we maintain in a designated record set, be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To qualify for consideration, your amendment request must be in writing, dated, and signed by you or your legal representative, and must state the reasons for the requested amendment/correction. Should we make an amendment/correction that you request, we may also notify others within our organization(s) for the amendment/correction of your records that they maintain.

Accounting for Disclosures of Protected Health Information. You have the right to receive an accounting of certain disclosures of your protected health information that we make, after November 1,2011 . Requests must be made in writing, dated, and signed by you or your legal representative.

Restrictions on Use and Disclosure of Protected Health Information. You have the right to request restrictions on certain of our uses and disclosures of your protected health information. We are not required to agree to your restriction request but will attempt to accommodate reasonable and legal requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe the termination is appropriate. Should we terminate a request, we will notify you. You also have the right to terminate any restriction you impose on us, by providing our organization with a written termination, dated, and signed by you or your legal representative.

Alternative Means/Alternative Locations. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests for alternative means of communications and/or locations. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request to our Privacy Officer.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with our Compliance Officer. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Access Fees. We will impose reasonable cost-based fees for certain work and expenses that we incur at your request to provide you with access to information. Such access fees may be imposed for copying, including supplies and labor, postage, and labor in the preparation of explanations or summaries of your protected health information. Such fees will be billed to you as the result of your request for your information and you agree, herein, to pay such fees as charged.

PATIENT PORTAL

Purpose of this Form Wakulla Urgent Care & Diagnostic Center offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is, therefore, intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site.

How to participate in our Patient Portal:
You can compose, pick up, and reply to secure messages or view information sent to you through a Web site hosted by our electronic records company. Once this form is agreed to and signed, we will send you an email that tells you how to register for the first time. This notification will give you the URL (internet address) of the Web site where you can log in. By clicking on the URL you will activate your internet browser, which will open the Web site. You will then be able to login using the user name and password provided. Next, you will be able to look in your "message box" and see any new or old messages or view other parts of your electronic record. Because the connection channel between your computer and the Web site uses "secure sockets layer" technology, you can read and view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting your Private Health Information and Risks
This secure method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two points are followed. We need to make sure we have your correct email address, and that we are informed if it ever changes. You also need to keep track of who has access to your email account, so that only you, or someone you authorize, can see the messages you receive from us. If you pick up secure messages from a Web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the Web site and change it. It is our intent to offer this is a free service, but we reserve the right to change this policy if needed in the future. We will provide adequate notice should this have to happen. We understand the importance of privacy in regards to your healthcare, and will continue to strive to make all information as confidential as possible. We will never sell or give away confidential information, including e-mail addresses, without your prior written consent.

Conditions of Participating in the Patient Portal
Access to the secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. You agree to not hold Wakulla Urgent Care & Diagnostics Center or any of its staff liable for network infractions beyond their control.

All Policy and Procedures are subject to change without notice.

PATIENT PORTAL

Wakulla Urgent Care & Diagnostic Center
41 Feli Way
Crawfordville, FL 32327
(850)926-3140

Instructions

How to Use the Patient Portal

1. Request access from our office.

2. Review and sign the Portal Activation Form (Available from our website or at the office).

3. You will then receive a welcome email, from which you can log into the portal.

4. Once logged into the portal, click the "My Account" button on the top right. Here you can change your username and password to something only you will know. *This is essential to ensure security and privacy!*

5. You are now set to use the portal!

Available Components:

1. *Messages:*
   This component allows you to send and receive secure email to/from our office staff.
   When you receive a message from our office, you will receive an email asking you to log into the secure Patient Portal to retrieve it. You may also send messages to our office staff.

2. *Lab/test Results:*
   Here you can receive copies of labs/tests ordered by our office.

3. *Health Summary:*
   This section allows you to view parts of your electronic medical record we have on file. The information in this section is information which has been provided by you, mostly based upon forms you filled out on your first visit. You can comment or request changes to the information, and once approved by a staff member those changes will be reflected online.

4. *Medications:*
   Here you can see your current and past medications written by our office or entered by our staff. Medications which do not list a physician are ones not prescribed by our office, but are ones you told us you are taking.

5. *Appointments:*
   In this section, you can view upcoming appointments. Additionally, when an appointment is closed, you will receive a reminder message.

Wakulla Urgent Care & Diagnostic Center
41 Feli Way, Crawfordville, FL 32327-2368
David A. Keen, MD & Valerie M. Russell, ARNP

Name: _____ Date of Birth: _____

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

I, _____ (Print name) have received a copy of the Patient Bill of Rights and Responsibilities and have read them or had them read to me.

_____

Signature of Patient Date

INFORMED CONSENT TO USE PATIENT PORTAL PATIENT INFORMATION

Name _____ Date of Birth_____

Address _____

Email Address _____

_____

Signature of Patient Date

PATIENT FINANCIAL RESPONSIBILITIES AND BILLING

Your signature certifies that you have read and understand all information stated in the PATIENT FINANCIAL RESPONSIBILITIES AND BILLING.

_____

Signature of Patient Date

_____

Signature of Staff Member Date