# PATIENT DEMOGRAPHICS AND PRACTICE PATIENT POLICIES DISCLOSURE/CONTRACT NP-1

**DATE:**_____
*Fecha*

**NAME**: _____ **AGE:**_____
*Nombre* (Last, First, Middle) **As name appears on Photo I.D.** *Edad*

**DATE OF BIRTH:** _____ **MALE**: ____ **FEMALE**: ____ **SS#:** _____
*Fecha de nacimiento* *Hombre* *Mujer* *(Seguro Social)*

**HM. ADDRESS**:_____**City:** _____ **State** _____ **ZIP**:_____
(*Dirección)* *Ciudad* *Estado* *(Código Postal)*

**PHONES: CELL:** _____ **HOME:** _____ **WORK:** _____
*(Numero de telefono)* *(Numero de trabajo)*

**E-MAIL:**_____

**EMPLOYER**: _____
*Empleo*

**PHARMACY NAME:**_____ **PHARMACY #:**_____
*Nombre de la farmacia* *Numero de la farmacia*

**24 HOUR PHARMACY NAME:**_____ **24 HOUR PHARMACY #:**_____
*Nombre de la farmacia* *Numero de la farmacia*

**MARITAL STATUS:** ___**SINGLE** ___**MARRIED** ___**WIDOWED** ___**DIVORCED** ___**SEPARATED**
*Soltero* *Casado* *Viudo* *Divorciado* *Separado*

## INSURANCE INFORMATION:

**IS THIS A WORK RELATED INJURY? (WORKMAN'S COMP.)** **YES_____** **NO_____** **DATE OF INJURY:**_____

**RESPONSIBLE PARTY : DOB**_____ **(circle one)** **SELF** **SPOUSE** **PARENT** **OTHER**_____

**TYPE OF INSURANCE:** **PPO** **INDEMNITY** **MEDICARE** **WORKCOMP** **HMO** **OTHER**_____

*(***NOTE*** IF HMO, MUST HAVE A REFERRAL FROM PCP PRIOR TO BEING SEEN)*

**INSURER'S PARTICIPATING LAB:** Labcorp:_____ Quest:_____ Other:_____
**NOTE:** It is your responsibility and complete financial liability to notify us of any special insurance benefits/contractual requirements for lab work or other testing, imaging services, therapy facilities, other healthcare providers, etc.

**IN CASE OF EMERGENCY**

**CONTACT:**_____**RELATIONSHIP**:_____

**PHONES: CELL:** _____**HOME:**_____ **WORK:** _____ **EXT:**_____

**REFERRED BY:** **DOCTOR**:_____ **OTHER**:_____
*Recomendado por*
**PHONE NUMBER:**_____ **ADDRESS:**_____

**EMAIL:**_____

## CONTACT INFORMATION:

**WHERE CAN WE LEAVE MESSAGES CONCERNING CONFIDENTIAL, PERSONAL HEALTHCARE INFORMATION?**

**PHONE:** _____ **E-MAIL:**_____

**SIGNATURE:**_____ **DATE:**_____

**(MOVE ON TO SECOND PAGE…)**

**Service Providers**= Rensimer & Associates, P.A.; IVRx Outpatient Therapy Services, Inc; ABx Pharmaceutical Services Enterprises, Inc; and International Medicine Center Enterprises, Inc.

**1. Assignment of Benefits**

_____ Initials

I hereby assign to the physician(s) and nurse practitioners all payments for medical services rendered to myself or my dependents. I understand that I am personally ultimately responsible for the entire amount due for medical service and supplies provided for my care. Insurance coverage may be accepted to pay a portion of the bill for services rendered. However, the service providers, physicians, and supportive staff are not obligated (unless otherwise agreed to by the Service Providers and the payor by contract) to accept payment from third-party payors (such as medical insurance payors, employers, etc.), and in fact, may require payment at the time of service. Should a third-party payor claim a medical service and/or supplies are medically unnecessary, that does not relieve the recipient (or their responsible agent) from complete and total financial responsibility to pay for the services and/or supplies.

**2. Payment Policy (Due at the Time of Service)**

_____ Initials

I understand that the service charges for which I am responsible (including but not limited to copays, coinsurance, deductibles, and practice assessed service fees) are to be paid at the time of service, irrespective of insurance coverage. Moreover, I am responsible for any charges particular to my credit card or other means of payment I am using and will be billed for those fees related to my means of payment.
It is the prerogative of the providers of services and medical care whether to await payment from an insurer for services rendered. I understand that if I have any questions about my financial responsibilities I can ask to speak with a billing staff member.

**3. Returned Check Fee**

_____ Initials

I understand that, if my check is returned unpaid for any reason (including Insufficient Funds or Stop Payment), I will be assessed a **$25 per check** processing fee and a **$15.00 charge for the return receipt notification** if the check has not been replaced in 30 days. I am aware that if I write a bad check the case may be referred to the Harris County District Attorney's office as a criminal matter.

**4. Cooperation in Collections**

_____ Initials

I understand that I must cooperate with the service and medical care providers' efforts to collect funds from any third party payor(s). I understand that I may be held immediately responsible for the full amount due for my medical care if I do not provide information required for the providers and the third party payor(s) to timely complete the financial transaction of payment for my care.

**5. Attorneys/ Court Costs in Collections**

_____ Initials

In the event the providers are forced to sue for any unpaid debts, I agree to pay consequent attorneys' fees and any other court costs and expenses associated with collecting an outstanding financial balance or debt incurred by the patient and owed to the Service Provider.

**6. No Refunds/No Returns**

_____ Initials

I understand that refunds or returns of medical supplies or medications shall not be accepted for credit unless an error was made on the part of the providers or pharmacy. In the event you do not use all of the medication that was dispensed, you may return it solely for disposal, not for credit or refund.

**7. Financial Interest Disclosure**

_____ Initials

This is to notify you that Edward R. Rensimer, MD has a financial interest in the following companies to which you may be referred for medical services: ABx Pharmaceutical Services Enterprises, Inc.; International Medicine Center Enterprises, Inc.; and IVRx Outpatient Therapy Services, Inc. If Dr. Rensimer recommends services that are provided by these companies you have the right to obtain such services elsewhere by other providers of your choice, provided their quality of care and performance are acceptable to Dr. Rensimer.

**8. Insurance / Healthcare Entity Disclosures**

_____ Initials

I hereby authorize the physician(s) or other staff of Rensimer and Associates or International Medicine Center (IMC) to furnish information to my insurance carriers, third party payor(s), and other healthcare entities as provided for in the Notice of Privacy Practices.

**9. Financial Liability for Changes in Treatment**

_____ Initials

I understand that the Service Providers or their staff are not liable for any costs incurred as a result of changes in treatments or case management. This includes unused medications, additional copays for prescriptions or other medical services, diagnostic testing, "pre-existing condition" denials, or "exclusion" denials or other out-of-pocket expenses or charges related to any aspect of the care or services provided or recommended. We assume no financial responsibility for a service provider being "out of network" with your insurer. It is your obligation to find this out to inform us if you wish to get medical services from another provider for any reason.

**10. Preferred Laboratory, Diagnostic Imaging Providers, and other Medical Services Providers**

_____ Initials

The practice will try to accommodate payor preferred laboratory, imaging, and other medical services providers when possible. **However, you agree to not hold us financially responsible for any clerical or other mistakes made which resulted in a higher cost to you** (i.e. we refer you to LabCorp when your preferred laboratory provider is Quest Diagnostics) because of medical service provided **due to our referral to an out-of-network provider**.

_____ Initials

**11. Referrals**:

"A referral for services" (for services to be provided by the Service Providers) and to be covered by your insurance (with your deductible co-pay amounts responsibility) is the patient's responsibility to obtain from the source of the referral and to present to us.

**Note:** Our ultimate responsibility is to refer you for medical services to the most experienced, reputable, and qualified providers of medical services relevant to your problem(s) in our judgment. If this is in conflict with the provider choices in your insurer's network, we will advise you of our recommendations so that you can make an informed choice on where you will opt to receive such services, with you or your agent bearing 100% responsibility for that choice and any associated adverse outcomes.

**It is ultimately your responsibility to check whether other medical care or service providers to whom we refer you are in your payor network.**

_____ Initials

**12. Billing**

a) We only send statements to patients when there is a balance owed or we need help with the patient's insurance company. If you receive a statement and do not think you owe the balance, please contact our business office immediately.

**DO NOT DISREGARD THE STATEMENTS.**

b) We will send 3 statements without a statement fee. For every statement afterward, there will be a **$25.00** statement fee. If you do not respond in any meaningful and purposeful way, then, by law, we must start the collection process. There may be a **$150 collection agency fee** added to your balance.

We may work with a patient on an acceptable payment plan for settling an outstanding balance, entirely at our discretion. Otherwise, we will consider filing in Small Claims Court to recover.

c) Once an outstanding balance on an account has been established and the patient/client notified, the balance must be settled immediately or a 1½% / month interest charge will be applied to the balance.

_____ Initials

**13. Insurance**

**a**. If you have insurance, we may file the claim on your behalf. **It is the patient's responsibility to make sure we have the correct insurance information at the time of service**. We use the most current insurance information when we refer patients to outside service providers (physicians, hospitals, labs, home health companies, imaging centers, etc). If we have incorrect information, you may be sent to an out-of-network provider, possibly at increased cost to you.

**NOTE:** We cannot be held responsible for incorrect, out-of-date information from your insurer on in-network and out-of-network providers. **It is your ultimate duty to check on anyone to whom you are referred or from whom you may receive services on whether you will be charged in or out-of-network rates. That will be your financial responsibility.**

**b.** We are contracted with many insurance payors. **It is the patient's responsibility to contact their insurer to make sure we are in network**. **You are entirely responsible, ultimately, for payment in-full** for our services, **at the prices we charge** for those services, **whether we are in or out of network**; if we are in a contracted relationship with your payor, then you are responsible for the "allowed amount" and/ or contracted rates of charge for our services. **If your insurance payor deems medical services and/or supplies provided by us as medically unnecessary or decline payment for any other reason whatsoever, you or your legally responsible agent are completely responsible for payment of the entire amount immediately.**

**c**. **You are responsible for keeping up with any changes in your insurance coverage**, **including**, but not limited to, changes in benefits, changes in insurance payor, changes in primary and secondary coverage, and changes **in healthcare providers considered in-network by your insurer**. When you are accepted by Rensimer and Associates, P.A., by ABx Pharmaceutical Services Enterprises, Inc, or by IVRx Outpatient Therapy Services, Inc as a patient or client, it is a de facto contract between the Service Provider and you, the terms of payment established by both parties on a cash (self-pay) basis, on the basis of your existing insurance coverage benefits, or other mutually agreed upon means of payment. **If at any time during the provision of services by these entities any such terms of payment change, it is the patient's or their agent's duty to immediately notify the Service Provider, at which point the Service Provider may opt to discontinue service, change the terms of service payment, or accept the new terms of payment. Failure to immediately notify the Service Provider of a change in the terms of payment, such that the Service Provider is placed into financial jeopardy for cost or denied changes for their provided services, may be construed as fraudulent and subject to legal action and criminal penalties.**

**In any event, the patient, client, or their agent are ultimately responsible for their entire financial balances owed to the Service Providers. It is their responsibility to immediately notify us of "pre-existing conditions" excluded from your insurance benefits coverage as well as any other "exclusions" under your coverage. Failure to do so will mean you are completely liable and responsible for all charges for services for such medical issues and this may be cause for immediate termination of the physician-patient relationship and legal action.**

If your insurance coverage has been obtained from a state or federal insurance exchange under the federal Affordable Care Act ("Obamacare"), **your benefits and in-network provider list may have changed or continue to change at any time**. As stated above, **you or your agent are entirely and ultimately financially responsible** for any charges for any services, equipment, or products received from Rensimer & Associates, P.A.; ABx Pharmaceutical Services Enterprises, Inc; or IVRx Outpatient Therapy Services, Inc., **irrespective of such changes.**

**14. Letters/Forms/Medical Supply/Copying Charges**

_____ Initials

Filling out forms, writing letters, and refilling prescriptions entails time-cost of our organization (and so, financial cost). The following charges will apply*****,

**a.** Customized fitness-to-work or **medical clearance letters**: **$75 - $150**
**b. Family** Medical **Leave** Act Papers: **$100**
**c. Customized** Physical **Exam Forms**: **$75-$150**
**d. Other forms**, depending on complexity and work burden on our staff: **$75-$150**
**e.** Customized **Back-to-Work** Documents: **$75-$150**

**NOTE**: Many insurers have a policy that with each **New Year prescriptions** must be **reviewed, re-authorized and refilled**. As this burdens our staff and takes their paid time to do,

1. You **must come in for an office visit OR**,
2. We will charge you **a $75 flat-fee**/per phone or FAX refill event for any medication refills not associated with an office visit or if done by mail-order.

**Prescription Refills**: **$75**/ refill event (for med **refills NOT ASSOCIATED with office visit**); If you wish an explanation of this, **please check this box** ☐ **STAFF:** If this box is checked, provide a copy of **Medication Refills Charge Procedure/Policy**

**f. Medical Disability** forms**:$50-$150,** for routine forms; higher charge pro-rated to time at the rate of $450/hr for extraordinary work burden.
**g.** Intravenous Medication Pole Deposit-**$200** (refunded upon return of IV pole)
**h. Case Summary** Documents: Charge based on time (physician = **$450/hr**; support staff **$50-$75/hr**).

**i.** Records **Copying** Charge: **$25** for first 20 pages, **50c** each additional page: (this charge applies to us copying our medical records of your care and may apply for recovery through our FAX receipt of your records from other providers and entities when of extraordinary volume).
**j. Other Customized Documents Creation or Completion**: Charged at the rate stated under "i*** The listed charges only apply to forms judged to be reasonable and customary** in their complexity, length, and work burden. If required forms exceed these expectations, **the physician reserves the right to augment the charges listed for such work.** The **individual requesting the form completion** will be provided the charges for the work prior to form's completion and **WILL BE EXPECTED TO PAY FOR IT UP FRONT**.

**15. Patient Pay for Medical Services Processing Work (caused by their insurer, or otherwise)**

_____ Initials

At times, insurance companies or other entities require extraordinary time from our non-medical and medical staff in dealing with them over medical services we deem to be medically necessary. Dealing with their bureaucracy (administrative staff, case managers, etc.) and system of in-network service providers (physicians, labs, imaging centers, and other entities) may impose time and documentation burdens on our staff in working for you, uncompensated by the insurer (not a covered benefit of the plan). Likewise, **part of an evaluation includes review of a REASONABLE amount of medical records**. If such review takes **more than 15 minutes, the physician will pro-rate additional charges for his time at the rate of $450/hr**. As soon as we are aware that such is the case, we will notify you that there will be a charge for work done at the following rates:

Non-medical support staff: **$50/hour**
Medical support staff: **$75/hour**
Physician: **$ 450/hour**

**We will stop this process if you do not wish to proceed because of cost to you, but that will be against our medical advice** since the services for which payment is being required are medically necessary.
**Examples** of such possible situations where we will charge you directly for our time at the above rates are **insurance pre-authorization**, **pre-certification**, and **denial of coverage appeals processes**, and **review of your case records sent by other medical providers or provided. Your insurer will not pay this cost** and we cannot absorb it.

**16. Self-Pay (uninsured or no covering third-party)**

_____ Initials

A **$1,000.00 retainer** is required **prior to service** in an immediately verifiable form: cash, money order, certified cashier's check, verifiable credit card, or other means, if accepted by the service provider.

For Intravenous patients, a **$3000.00 retainer** is required **prior to service** in an immediately verifiable form: cash, money order, certified cashier's check, verifiable credit card, or other means, if accepted by the Service Provider.

For In Vitro Fertilization Cases, a **$500.00 retainer** is required **prior to service** in an immediately verifiable form: cash, money order, certified cashier's check, verifiable credit card, or other means, if accepted by the Service Provider.

**For Rabies Post-Exposure Services** the entire projected cost of HRIG, vaccine, and physician/support staff time **may need to be be paid up-front**. (at our discretion).

**Ongoing services must be covered by maintaining the above retainer balance** to replenish used up funds. When the final financial balance for services provided is settled, the remaining funds will be returned to the patient or their agent.

_____ Initials

**17. Failure to Cancel an Appointment (a "no-show")**

I understand that a failure to cancel an appointment (or a "no-show") may result in a charge to the patient, client, or their agent of **$100** unless,

**a.** There is a proven reason of extraordinary, unpredictable emergency (acute physical incapacity, car accident, etc.) that made contacting us impractical and understandable, and that reason is acceptable to the physician and not part of a pattern of behavior.

**b.** The missed appointment loss can be otherwise neutralized by replacement work.
**A mutually respectful relationship requires that you timely inform us of your inability to attend your scheduled appointment.**

**c. A pattern of this behavior will likely result in termination of our relationship, as will failure to pay no-show fees.**

_____ Initials

**18. Email Communications with Our Organization**

Our organization, on an as needed and time and content limited basis, is willing to communicate with you by email under our well-defined policy and rules for such exchange of medical information. If you wish to enable such communication, **please check this box ☐ . STAFF:** If this box is checked, provide Email Medical Communication Informed Consent Form.

**Note: WE STRONGLY DISCOURAGE EMAIL EXCHANGE OF INFORMATION REGARDING HIGHLY SENSITIVE PERSONAL HEALTH INFORMATION:** psychiatric issues, alcohol/substance abuse matters, sexual or sexually-transmitted diseases issues.

_____ Initials

**19. Scheduled Appointment Times**

We try our best to adhere to our scheduled appointments in a timely manner. At times, usually in response to the unforeseeable medical needs of others, we get off schedule. We will try to keep you informed so that you can decide to re-arrange your schedule or to even change your appointment, to minimize waste of your time.

Likewise, we expect you to arrive on time. For a new patient (first time) appointment or return appointment at least a year after your last time here, **you must arrive sufficiently in advance of your scheduled time** to update your medical information; at least 30 minutes is suggested. If you do not, such that it substantially impacts the scheduled appointment times of others, we may be forced to re-schedule you to another time. **We suggest you prepare for 3 hours with us from entry to exit if you are a New Patient.**

**A pattern of no-show/appointment cancellations or lateness may result in the termination of the patient from the practice** in that such behavior constitutes a disrespectful comment on the physician-patient relationship and our staff.

_____ Initials

**20. AFTER-HOURS PHONE CALL CHARGES to Patient (see attached document) Prorated to time at $450/Hr. (minimum charge=$100)**

_____ Initials

**21. Pre-Existing Conditions/Self-Pay Status:** It is your obligation to know which, if any, of your medical conditions are considered "pre-existing" (not covered) by your current insurance carrier and to notify us of these if they are the object of our services. If so, we will consider our time, expertise, and other services as **NOT COVERED BY INSURANCE**, and so payment **WILL BE HANDLED UNDER OUR SELF-PAY POLICY**.

_____ Initials

**22. Disclosure and Acknowledgement of Workers' Compensation Information:** The Texas Workers' Compensation Division ("the Division") regulates fees and charges for medical care, hospital services, and medicines. The Division sometimes determines some fees and charges, such as charges for a hospital private room, are unrelated to the Workers' Comp. covered injury or illness. If the Division determines fees and/or charges will not be reimbursed, **you or your agent accept responsibility for complete payment of any fees and/or charges** that are not covered by Workers' Compensation coverage, **immediately** upon receipt of notice of such an outstanding financial balance.

_____ Initials

**23. Ultimate Financial Responsibility**

**NOTE:** Ultimately, it is the **responsibility of you or your guardian or your agent to assure** that your medical **care is financially efficient (as in "in-network").** Our responsibility is to provide the most timely, medically best care feasible. We will attempt to manage your case and care in a financially beneficial and responsible manner, but it is neither our obligation nor focus.

**a. You** must **provide up-to-date insurance and payor network providers of services information** or other third-party payor information to us **at each service event or visit**, and **as soon as you become aware of any change** in such information.

**b. You** must personally **check whether any referrals we make are financially suboptimal** and immediately notify us of this.

**c.** When possible, we will try to consider both financial and medical case aspects as priorities, but our ultimate focus is on optimal medical services and care.

**d. You** are obligated to be a **self-informed expert on such financial issues** and are ultimately personally, financially responsible for all service and supply charges, in whole and immediately upon request, **for your medical care**, irrespective of insurance or other third-party payor coverage or lack of it for all or any part of services.

_____ Initials

**24. Freedom of Choice Relationship**: Just as you have the choice to use whatever medical professionals you feel will serve your best interests, we reserve the right to take on, continue on, or decline your case or to terminate the relationship. That decision is based on our willingness to participate for a variety of reasons including, but not limited to: case-specific professional capability, case time demands, interpersonal chemistry with patient and/ or their agents, insurance payor administrative burdens, financial

issues, or personal choice. Regardless, we will always responsibly transfer your care, **though it is not our responsibility to locate our replacement or other medical care providers to take your case**. Upon notice of our unwillingness to continue on your case if we have established a physician-patient relationship, our only continuing responsibility will be to provide emergency care for situations we are qualified to handle for 30 days after our notice to you of termination of our relationship with you.

**If you are running late, we expect you to call** so that we can decide whether we can still see you that day. We cannot have time-drift due to significantly late patients (over 15 minutes), imposing this on others waiting in line who are on-time (as you would wish for yourself). The chain-reaction resulting brings about emotional distress in all the other patients and our staff, as well as overall poor service and performance.

_____ Initials

**25. Patient Follow-Up on Test Results/Case Management Plan: If a patient or their agents have not heard back** from the physician or this organization in a reasonable amount of time with respect to your understanding of the expected turnaround time for medical test reports or the urgency of the clinical condition of the patient, the patient or their agents **should take the initiative to call our staff** to request direction on the next steps for their case. If, for any reason, you cannot get a timely response, please **take the initiative to come to the office** to assure you are heard and responded to by the physician. This policy is so stated to safeguard your medical interests as a fail-safe measure against organizational errors, apathy, or inattention. We are committed to your welfare and cannot put you at risk due to errors or inattention by individual staff members who may not be exercising the unparalleled professionalism that is the core value of our physician and this organization. So, in this spirit, we are asking that you oversee our service to you so that we meet the most demanding expectations and duty to you.

_____ Initials

**26. No Responsibility for Insurer's Coverage or Refusal to Cover Ordered Tests/Procedures:** The physician orders tests considered indicated for medical conditions and problems. That is often before any valid diagnosis can be applied (that is usually the point of testing). Yet, oddly, Medicare and other insurers will deny payment for such testing because they have their particular criteria justifying such testing. We cannot possibly be held accountable to know all the (changing) criteria for an insurer's payment for a test or procedure. If you are notified by a lab or imaging center that you are responsible to personally pay for a diagnostic study, we will work in good faith to see if we can revise terminology (short of misrepresenting) to achieve insurance coverage. However, if this involves significant physician or staff time, we will expect payment from you **in accordance with Item 15 above**. Be clear, this imposed business bureaucracy is not of our making and is not our responsibility. We are here to practice medicine.

**My initials in the left-hand margins above and signature below indicate I have read all of the above, have had an opportunity to ask questions, understand the terms of service, and agree to abide by them.**

**We realize that financial matters and medical insurance benefits can be confusing, complex, and time consumptive. Let our staff help you with any uncertainty or clarifications**:

_____
Patient (Signature) Date

_____
Patient (Printed Name)

_____
Patient's Agent (Signature) Date

_____
Patient's Agent (Printed Name)

_____
Service Provider Staff (Signature) Date

_____
Service Provider Staff (Printed Name) Date

**ATTENTION STAFF:**

**1.** Be sure to **validate the identity of the person completing this form** by checking some type of **photo ID**. Check the box and initial that you have done so.

☐ **Photo ID** Checked

_____ Initials

**2.** If the individual completing this form (see **item 19,** page 4 above) wishes to use email with our organization, provide our **Email Policy and Informed Consent**. Check the box,

☐ **Email Policy**/Informed Consent Packet **provided** to the patient/patient's agent.

**3**. ☐ Email Policy/ Informed Consent received signed by this patient or their agent.

_____ Staff Initials

*PLEASE HAND THIS COMPLETED FORM TO THE RECEPTIONIST*
*WITH YOUR PHOTO IDENTIFICATION AND HEALTH INSURANCE CARD.*