

# Medical Associates of Katy

Sohail Noor, MD, FACP, Saba Noor MD, Amito Chandiwal MD, Syed Moosavi, MD

## Patient Copy: FINANCIAL POLICY

Thank you for choosing Medical Associates of Katy as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

**All patients must read and sign this form prior to receiving services.**

☞ **It is your responsibility to provide us with your most current insurance information.**

☞ If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

☞ We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.

☞ If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered.

☞ We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**

☞ Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers, or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

☞ We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

☞ Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

☞ **It is your responsibility to provide us with your most current billing information.**

☞ You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

☞ We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call **(281)206-8070**.

☞ **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be referred to a professional collection agency for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.

☞ If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.

☞ In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

☞ We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

☞ **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

☞ Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

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## PATIENT COPY: POLICY

### **APPOINTMENT POLICY:**

Our goal is to provide quality individualized medical care in a timely manner. “No-shows”, and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

### **CANCELLATION OF AN APPOINTMENT:**

In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Associates of Katy promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

### **HOW TO CANCEL YOUR APPOINTMENT:**

To cancel appointments, please call 281-206-8070. If you do not reach the receptionist, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

**Late Cancellations:** A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice

### **NO SHOW POLICY:**

A “no-show” is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a “no-show”.

**Each missed appointment: \$25.00 fee will be billed to your account. Initial: \_\_\_\_\_**

### **OTHER FORMS:**

Please be advised that all forms that require your physician to complete are subject to a \$25.00 fee. The fee must be paid at the time the blank form is given. Forms include but are not limited to Family Medical Leave of Absence (FMLA), Employment forms, Disability information, and other documentation requiring the physician’s signature.

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## HIPPA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information 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.

### **Uses and Disclosures of Protected Health Information:**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians' practice, and any other use required by law.

### **Treatment:**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For Example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

### **Payment:**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

### **Healthcare Operations:**

We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians' practice. These activities include, but are not limited to, quality assessment activities, Employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization.

These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physicians' practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. 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 or proceeding, and protected health information that is subject to law that prohibits access to protected health information.