The Health Associates of Tampa
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Office and Financial Policies

We would like to thank you for choosing The Health Associates of Tampa as your primary care provider, where your health is our priority. We are committed to provide our patients with high quality medical care in a cost-effective manner. To accomplish this, we depend on receiving prompt payment for our services. To keep you informed of our current office and financial policies, we ask that you read and sign acknowledgment of our policies prior to any treatment Please keep this document for future reference.

1. No Call No Show Appointments: A No Call No Show appointment is when a patient fails to show for a scheduled appointment. **The Health Associates of Tampa reserves the right to charge a $125 fee for a No Call No Show Appointment.** The patient is expected to pay this fee if charged to their account prior to their next scheduled appointment. If a patient has **three (3) No Call No Show appointments within one (1) calendar year**, the practice reserves the right to terminate the patient from the clinic. If patient refuses to pay the fee, the practice reserves the right to terminate the patient from the clinic and has the right to send patients account to collections and charge additional legal fees if necessary.

2. Same Day Cancellation: If a patient calls and cancels an appointment less than 24 hours before the scheduled appointment time, **The Health Associates of Tampa reserves the right to charge a $75 fee.** The patient is expected to pay this fee if charged to their account. If patient shows a habit of cancelling within less than 24 hours on a regular basis, the practice reserves the right to terminate the patient from the clinic. If patient refuses to pay the fee, the practice reserves the right to terminate the patient from the clinic and has the right to send patients account to collections.

3. Late Appointment: A patient is considered late if they show up 15 minutes after the scheduled appointment time. If patient shows up late and the provider is unable to accommodate within their schedule, patient will be expected to reschedule their appointment. If patient is late, and the appointment is for a medication review, the provider is under no obligation to provide an extension of medications to any patient. If the provider chooses to extend this courtesy, it will be a one-time courtesy. If the patient shows a habit of showing up late to appointments, the practice reserves the right to terminate the patient from the clinic.

4. Medication Refills: It is the patient's responsibility to provide sufficient time for a refill request from a provider before patient runs out of medication. Refill requests will only be filled Monday – Friday during regular business hours of 9:00 am – 5:00 pm. Patient needs to allow a minimum of 48 hours for a refill to be acknowledged and filled or denied with explanation. Requests can take up to 72 hours at times.

5. Controlled Medications: Florida state law requires that if a patient is on a controlled medication that the patient must be seen **in office by a provider once every three (3) months**. It is the patient's responsibility to be sure to schedule these appointments as well as show for the appointment on time. The provider is not obligated to provide any extensions of refills if the patient does not make and/or keep these state law required appointments.

6. Adderall Refills: If a patient is prescribed Adderall, they are required to have an in-office appointment once every three months. At the time of this appointment, the patient will be provided three months of paper prescriptions. It is the patient's responsibility to keep track of these prescriptions as the provider will not be able to provide a duplicate prescription. If patient loses or has a prescription stolen, the patient must file a police report and provide a copy for records for a replacement prescription to be considered.

7. Payment for Services Rendered:

    a. Patients with Medical Insurance: Please bring your insurance card with you at the time of your appointment.

        i. Patients are responsible for knowing the benefits covered by their insurance policy. Our services are documented to comply with federal law and will be billed accordingly. Verification that our providers are "in network" with an insurance plan is the patient's responsibility. Patients are responsible for verification that all referrals or prior authorizations are attained before services are provided, as imposed by their benefit plan.
        ii. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, a processing fee will be added to your account to cover additional billing expenses that will be incurred.
        iii. Patient is responsible for any co-insurance deductibles or non-covered services as required by your insurance. You will receive a statement from our third-party billing company, Premium Billing Solutions, indicating what your insurance has paid. Any remaining balance is due upon receipt of this statement. Any balance over 60 days will be assessed a late fee. A payment can be arranged with our Billing Department upon request.
        iv. As stated, The Health Associates of Tampa utilizes a third-party billing company. Charges could take several weeks for the office to be notified that our provider and/or clinic, or certain services are not covered by a patient's insurance plan. With each insurance company having multiple plans, it is not possible for our office staff to know the details of each patient's individual plan. Due to this, it is important to stress that it is the patient's responsibility to understand and know their benefits and coverage.

v. It is the patient's responsibility to provide a copy of any new or updated insurance cards received from insurance carrier as a new card could contain different information when filing any claims.

b. Patients without medical insurance; Self-pay / Cash

i. Payment will be due prior to services rendered. A new patient appointment is **$175** and a follow-up for an established patient is **$125**.
ii. If you are unable to pay your balance in full, arrangements must be made and approved by management within the office prior to services being rendered.
iii. Any outside services that may be recommended during appointment, such as labs or imaging, an order will be provided to the patient, and it will be the responsibility of the patient to seek these services on their own.

c. Payment: The Health Associates of Tampa accepts a variety of payment methods. We accept cash, checks and major credit cards.

d. Returned Checks: a **$50** charge will be added to your account for any check returned by your bank for any reason. This is subject to change based on bank charges.

8. Auto Accidents, Liability Injuries and Workman's Comp: The Health Associates of Tampa does not participate in these services currently. If you are an established patient and need to be seen for one of these types of appointments, please contact our office for a referral to our recommended offices that can assist you with these needs.

9. Medical and Other Forms: There is a minimum fee of $20 for the completion of forms such as school physicals, school sports, employment, adoption, fitness center, FMLA, disability forms, etc. The charges are based on and can increase with the number of pages and complexity of information requested. Please speak with the Office Coordinator after presenting the forms to discuss the amount that will be charged for the completion of requested forms.

10. Medical Records: The Health Associates of Tampa will provide you with a copy of your medical records upon request.
    a. You will need to complete and sign a Release of Information (ROI) form before we can begin the request.
    b. Allow 7 – 10 business days for completion.
    c. The fee for printed records is $1 per page up to $25, and then .25¢ per page after that.
    d. If records must be mailed, the mailing fee will also be the patient responsibility.
    e. Records that can be provided electronically do not have a fee.

PATIENT NAME_____ DATE OF BIRTH_____

PATIENT SIGNATURE _____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by The Health Associates of Tampa. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles, and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to The Health Associates of Tampa for any medical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges as outlined in office and financial policies guidelines. I acknowledge that I have received a copy of the office policies.

Signed_____ Date_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby give my consent to The Health Associates of Tampa to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations all protected health information contained in the patient record of (patient name) _____.

For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that The Health Associates of Tampa reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on The Health Associates of Tampa's website and will be posted at the office.

We may make your protected health information available electronically through an electronic health information exchange to other health care providers that request your information for their treatment purposes. In all cases the requesting provider must have or have had a treating relationship with you. Participation in an electronic health information exchange also lets us see other provider's information about you for our treatment purposes. I acknowledge and consent to the use of artificial intelligence (AI) technology by The Health Associates of Tampa for summarizing my Patient-Doctor interactions. This AI tool aids in efficient documentation, ensuring accurate medical records, and adheres to strict privacy standards in compliance with relevant laws.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied upon it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed _____ Date_____