Hill Country Orthopaedic Surgery & Sports Medicine
Wayne A. Lee M.D.
19016 Stone Oak Parkway Suite 220
San Antonio, TX 78258
(210) 491-4125 Phone
(210) 491-4138 Fax

NOTICE OF INFORMATION PRACTICES

HOURS OF OPERATION: Monday thru Friday 9:30am to 5:30pm
Closed for lunch from 12:00pm to 1:30 pm

AFTER HOURS: There is a physician on call at all times. In the event of an after hours emergency, please call our main number and you will be forwarded to our answering service who will then page the doctor on call.

APPOINTMENTS: You should arrive for your appointment at least 15 minutes prior to your scheduled time. We will do our best to minimize your wait time, however, emergency situations arise and may delay your appointment. If you have changed your phone number, address, insurance carrier, or any other personal information, please make sure to notify the receptionist. This information is critical to the proper filing of insurance claims.

CANCELLATIONS: If your are unable to keep your appointment, we ask that you at least notify us 24 hours in advance so that your time slot will be available for another patient.

PAYMENTS: Regardless of your insurance coverage YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT ON YOUR ACCOUNT. We ask that you keep your account current. Hill Country Orthopaedic Surgery & Sports Medicine will not bill for services. Please be prepared to pay on the day of your visit.

RETURNED CHECKS (NSF): Pursuant to SB-921, you will have 10 days to tender payment, plus a $25.00 bank service charge on all NSF checks. If payment is not received within that period, the NSF check will be forwarded to the District Attorney for collection.

DELINQUENT ACCOUNTS: It is your responsibility to understand your insurance benefits. HCOS will file a claim to your insurance company for services rendered. If your account becomes ninety days delinquent, it will be placed in collection status. We will exhaust all measures to contact you if your account becomes seriously delinquent. If you do not respond or if we are unable to contact you, your account may be turned over to a collection agency.

MEDICAL RECORDS, SPECIAL FORMS, & ITEMIZED BILLING STATEMENTS: Please be advised that there is a fee for copies of medical records and itemized billing statements. It is $25.00 for the first 20 pages and $0.15 a page thereafter. Special forms such as, FMLA forms, disability forms, attending physician forms, etcetera, will be completed for a $25.00 fee in addition to your copayment if you have a scheduled appointment.

PRESCRIPTIONS/REFILLS: Please contact your pharmacy if you need medication refills. They will in turn contact our office for approval. If you need written prescriptions, please give us at least one weeks notice.

Thank you for your cooperation.

X _____

Patient/Parent Signature Date

Hill Country Orthopaedic Surgery & Sports Medicine

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

I understand that as a part of my healthcare, Hill Country Orthopaedic Surgery & Sports Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many 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 third party payer can verify that services billed were actually provided*
- *And a toll for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Information Practices that provides more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Hill Country Orthopaedic Surgery & Sports Medicine reserves the right to change their notice and practices and prior to implementation will mail copy of any revised notice the address I have provided. I understand that I have the right to object to the use of my health information in any public directory of Hill Country Orthopaedic Surgery & Sports Medicine.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment, or healthcare operations and that Hill Country Orthopaedic Surgery & Sports Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Hill Country Orthopaedic Surgery & Sports Medicine has already taken action in reliance thereon.

Hill Country Orthopaedic Surgery & Sports Medicine records may contain information created by an entity other than Hill Country Orthopaedic Surgery & Sports Medicine. Hill Country Orthopaedic & Sports Medicine is not responsible for the information contained therein (including the accuracy, completeness, relevance, legibility, or lack thereof of such incorporated records.) Patient is expressly requesting release of all records maintained by Hill Country Orthopaedic Surgery & Sports Medicine concerning patient, including incorporated records. Patient acknowledges that Hill Country Orthopaedic Surgery & Sports Medicine has no and assumes no duty to patient regarding the consent of or omissions from such incorporated records.

_____ No Restrictions _____ I request the following restrictions to the use or disclosure of my health information: _____

X _____ _____

Signature of patient/Legal Representative Witness

_____

Date/ Notice Effective Date/Version

Hill Country Orthopaedic Surgery & Sports Medicine was unable to obtain acknowledgement/consent because:

_____ Emergency _____ Patient Non-Responsive _____ Patient Confused/Disoriented

_____ Patient sedated _____ Patient refused—reason: _____

This area for use by Hill Country Orthopaedic Surgery & Sports Medicine personnel only.

Restriction on use or disclosure: _____ Accepted _____ Denied

Signature: _____ Date: _____