**Southern Pines - Office Policy Letter**

The providers and staff at RPK Center for Rehab, Spine and Pain management feel that we can better serve your healthcare needs if you are familiar with the following policies and procedures of this practice:

**OFFICE HOURS AND INFORMATION:**

RPK Center in Southern Pines is currently only opened on Fridays 8:00am – 4:30pm. These times may change and our hours adjusted, so please check with us at visits for any changes. The Fayetteville office is open Monday – Thursday 7:00 am – 5:30 pm. Our phone number is (910) 725-0561.

**PHONE CALLS:**

As your providers assistant is not always available to answer your questions during office hours, you will need to leave a message on the designated voicemail. The assistant will reach out to you to further assist you. Although the Southern Pines office is closed on some days, you may still utilize the above number on any day during office hours.

**PRIOR AUTHORIZATIONS:**

If your medication needs an authorization, we ask that you have your pharmacy first send us a request. Every effort will be made to get them completed but this process may take up to 72 hours depending on your insurance.

**APPOINTMENTS:**

Appointments may be made by contacting our office at (910) 725-0561. This number can be used on any of the days of the office hours for both the Fayetteville and Southern Pines location during the above office hours.

If you are unable to keep your appointment kindly notify our office at least 48 hours in advance. A CHARGE OF $25.00 MAY BE INCURRED FOR NO SHOW APPOINTMENTS. FURTHER APPOINTMENTS WILL NOT BE SCHEDULED UNTIL THIS FEE IS PAID. LATE ARRIVALS WILL BE RESCHEDULED.

**As A COURTESY,** we attempt to contact you to confirm your appointment 24-48 hours prior, however, you are still responsible of keeping track of your appointments. You are given an appointment card after each visit with your next appointment date/time as a reminder. We are unable to accept “someone did not call me to remind me” as an acceptable reason for not attending your appointment. Please remember to keep your appointment card in a safe place or mark your calendar at home.

**EMERGENCIES:**

We do not treat emergencies, accept walk in appointments, and in most cases, schedule same day appointments. If your condition requires immediate assistance, please contact your primary care provider or the nearest Emergency Department. We do not have an on-call provider at this office, and the phone lines are only open during office hours.

**Financial Payment Policy**

**PAYMENT FOR SERVICES:**

* Patients are expected to pay at the time the service is rendered; however, if this is not possible, a copy of account charges will be provided the day of your visit.
* Payment of your account is expected within 10 days of receipt of charges.
* In the event payment cannot be made, special and specific arrangements may be made by calling our Patient Accounts Department.

**Our requirements for payment of your account and for maintaining your account in good standings are as follows:**

* All charges are due and payable within 10 days of receipt of statement. You will receive a statement each month detailing your account balance.
* You are directly responsible for all co-pays, cost shares, deductibles, etc. not covered by your insurance carrier.
* If payment cannot be made when due, you must contact our Patient Accounts Department to set up an extended payment arrangement.
* After 90 days, if no payment has been received and no extended payment arrangements has been made, necessary collection proceedings will begin. Appointments will not be scheduled for patients with accounts in collections.
* It is important that you notify us of any changes in address promptly since undeliverable statements are turned over to the collection agency immediately.
* In accident, legal cases, etc. where an insurance company or other party is presumed liable for expenses incurred as a result of your accident, injury, illness, etc., RPK Center looks to the party receiving such services is expected to take care of his/her account in line with the above guidelines.

**INSURANCE CLAIMS:**

* As a courtesy to our patients, we will bill your insurance company for services provided in our office. It is the responsibility of each patient to provide our office with accurate insurance information in order that we may file your insurance claim. If we are unable to file a complete and accurate claim with your insurance carrier due to the lack of information, the balance due on the account will be the responsibility of the patient.
* Our office will make every effort to verify insurance coverage, but it is the patient’s responsibility to contact their insurance company with any questions regarding pre-authorization, network participation, deductibles, cost shares, and co-payments. As we are a specialty clinic, it is important that you keep your primary care provider informed regarding your treatment with our office if authorizations/referrals are required.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name)

Have read and understand the following documents provided to me for review:

* Acknowledgement of Receipt of Privacy Notice
* Office Policy Letter
* Financial Payment Policy

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Witness) (Date)

**AUTHORIZATION TO FILE INSURANCE**

PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE: I authorize the release of any medical or other information necessary to process any and all insurance claims to my insurance carrier. I also authorize payment from my insurance carrier to the provider that accepts assignment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Witness) (Date)

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives the individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

* Home Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to leave message with detailed information? YES NO

If no, is it ok to leave message with call back number only? YES NO

* Work Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to leave message with detailed information? YES NO

If no, is it ok to leave message with call back number only? YES NO

* Cellular Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to leave message with detailed information? YES NO

If no, is it ok to leave message with call back number only? YES NO

* Written Communication:

Is it ok to mail PHI to your home address? YES NO

Is it ok to fax PHI to your work / office? YES NO

Please indicate with whom we **MAY** communicate regarding your PHI:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_­\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_­\_\_\_\_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use, disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. This information is recorded in the patient electronic medical record (EMR) and will constitute an adequate record.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient or Authorized Signature) (Date)