HEALTHCARE INSTITUTE OF NORTH FLORIDA
RICHARD L. WRIGHT, MD, RPVI

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PRESCRIPTION POLICY

It is the responsibility of the patient to manage and keep track of any and all prescriptions. As your physician, we will do everything possible to ensure that you receive your medication refills appropriately, but this can only be possible with the understanding and cooperation of the patient. Please read the following policies carefully. If there are any questions a nurse will be happy to assist you.

- Patients currently taking any long term medications which require refills shall have 12 Week (3 month) recheck visits for prescription verification and any routine laboratory work.

****ALL long term medications MUST be refilled at this visit**.

- Refills for medications are either sent electronically, or a written prescription is given directly to the patient. It is not a policy of this office to call in prescriptions to any pharmacy by phone[1].

- All long term medication prescriptions will be given for a **maximum of 90 days**[2] and shall be refilled at every 12 Week office visit.

- All patients taking Schedule II medications (Opiates) are required to have an office visit every 4 Weeks for prescription renewals. Prescriptions for Schedule II medications MUST be written and given directly to the patient.

- All patients taking any controlled substance will be required to sign a controlled substance agreement, and to provide a urine sample for a Urine Drug Test (UDT) periodically at the discretion of the physician.

- All patients taking any controlled substance must have a current Annual Wellness Visit or Annual Physical on file with our office.

[1] Exceptions may be prudent under rare circumstances
[2] Some mail order prescriptions may be eligible for longer refill periods

FINANCIAL POLICY

Thank you for choosing Health Care Institute of North Florida as your healthcare provider. We are committed to providing you with high quality care. Our Medical and Business Office staff members will work very hard to make sure you have a positive experience with us. Please make sure to read the following in its entirety and sign that you have read and understand this policy.

WE ACCEPT MASTERCARD, VISA, DEBIT CARDS, CHECKS, AND CASH.

Please read and then sign the following:

1. **Picture Identification**
   Due to widespread insurance fraud and identity theft, picture identification is required when you register in our office.

2. **Insurance & Insurance Collection**
   Please bring all of your insurance cards to **EACH AND EVERY APPOINTMENT**and notify the staff if there have been any changes to your policy. Please understand that insurance reimbursement can be a long and difficult process for our office. It is imperative that we have the most accurate and up to date information in order for claims to be filed in a timely manner.

3. **Medicare and Medicare Advantage Plans**
   As a participating provider, we will bill Medicare and your secondary (if applicable) or the Medicare Advantage carrier. You are responsible for your annual deductible and 20% co-insurance or any co-payments you may have which must be collected. If you have a Medicare Advantage plan, you must present us with the appropriate insurance card along with your traditional Medicare card. If a balance remains after we bill your insurance carrier we will bill you for the balance, which is payable by you upon receipt of our statement.

4. **Account Balances and Cost-Shares**
   All co-payments, deductibles, share of costs and co-insurances are due at the time of service. Your insurance company deducts this from our payment automatically. Bills unpaid for more than **60 days** will be turned over to a third party and/or collection agency. Additional fees may be incurred in the collection of any outstanding balances and may also result in your dismissal from the practice. I understand that failure to maintain a current account (i.e. an account balance that is less than $300.00) with The Health Care Institute of North Florida may result in further non-emergent medical treatments not being provided and/or dismissal from the practice.

5. **No Insurance or Services not Covered by your Insurance**
   Patients without any health insurance or patients who have coverage but the services are not covered by your insurance are expected to pay in full prior to or at the time-of service. This includes all office visits, tests, injections and surgical procedures. A minimum of $166.13 is expected on the initial visit. For extended treatments, payment arrangements are available and can be made with the billing office staff prior to any medical evaluation, procedure or treatment.

6. **About your information**
We require you to bring your insurance card(s) with you to **every office visit**. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undelivered.

7. **Form Completion and Record Copying**
From time to time, you may ask us to complete various forms (such as disability forms). There is a **$25** service fee per page to complete these forms. Payment is due prior to us giving those completed forms to you. This charge is not covered by your insurance company and offsets the costs we incur to complete these forms. Please allow 7 to 14 business days. Medical records to be released to another provider are provided at no cost. We offer CD's free of charge to all patients.

8. **Returned Check Fee**
There is a $30 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order, debit card or credit card.

9. **Authorization to Pay Benefits**
I authorize and direct said agency or insurance company to pay benefits, or insurance payments made on my behalf, directly to The Primary Care Center of Lake City d.b.a. Health Care Institute of North Florida, for professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my responsible portion when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

10. **Late/Missed Appointments**
Due to the limited number of patients our providers can see per day and the limited time they have for each patient, it is important that each patient keep their appointment. If you arrive **8 minutes** past your appointment you will automatically be rescheduled. If you are unable to make your appointment we ask that you give **24 hour** notice prior to your appointment. We understand that sometimes there are circumstances that are unavoidable and it's not feasible to contact us prior to your appointment but we must limit this number. Once you have missed three (3) appointments without prior notice you may be subject to suspension from the practice for one (1) year.

NOTICE OF PRIVACY PRACTICE

OUR PLEDGE TO YOU

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain.

We are required by law to keep medical information about you private, to give you this notice of our legal duties & privacy practices with respect to medical information about you, and follow the terms of the Notice that are currently in effect.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. If a change is made in policy, the Notice will be changed and posted in the lobby. You can receive a copy of the current Notice at any time. The effective date is listed just below the title.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose medical information about you for treatment, to obtain payment for treatment, and to support our health care operations. We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, coroner or medical examiner investigations, funeral arrangements and organ donation, workers' compensation purposes, product monitoring, repair and recall, lawsuits and disputes, to avert a serious threat to health or safety, national security intelligence activities, military command authorities, inmate information and emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

We may disclose medical information about you to a friend or family member who is involved in your medical care, or to disaster relief authorities so that your family can be notified of your location and condition.

The Health Care Institute will leave an appointment reminder on an answering machine if you are unable to answer your phone, and we will give you the date and time of the appointment made at that time.

OTHER USES OF MEDICAL INFORMATION

In any situation not covered by this Notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us of your decision in writing.

YOUR RIGHTS

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us, or if it is determined that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6 year period and starting after April 14, 2003. You may receive the list in paper or in electronic form.

The first disclosure list request in a 12-month period is free; other requests will be charged for producing the list. We will inform you of the cost before you incur any costs.

You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision of your request.

If you are concerned that your privacy right may have been violated, or you disagree with a decision we made about access to your records, you may contact Rayna Harris, our Privacy Officer.

All written requests or appeals should be submitted to our Privacy Officer,

Rayna Harris
Health Care Institute
1289 SW State Rd 47
Lake City, FL 32024

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Right. Our Privacy Officer will provide the address for you. Under NO circumstance will you be penalized for filing a complaint.