**Coastal Anesthesia, P.A.**

**Pain Management**

1001 W. College Blvd, Suite H

Niceville, FL 32578 Michael P. Ederer, D.O.

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**Clinic Policy**

**APPOINTMENTS**

Appointments can be made by phone or in person during normal business hours. If you have any changes in insurance or administrative information, please arrive earlier than your scheduled appointment time to make the changes. If we are running late, we will be happy to reschedule you for another appointment at a more convenient time.

**NO SHOWS**

Appointments at this clinic are in high demand and our doctor and staff work hard to accommodate all patients so that they may be seen as soon as possible. Medical care opportunities are lost when an appointment is missed or changed on short notice. If you cannot make a scheduled appointment we ask that you call at least **24 hours** in advance to avoid the following fees:

* 1st NO SHOW will receive a Courtesy letter at No Charge.
* 2nd NO SHOW $25.00 Fee
* 3rd NO SHOW $50.00 Fee – At that time your provider may choose to dismiss you from the practice.

These fees will be added to your account and must be paid in full before your next office visit.

Please honor your appointment by making changes in a timely manner.

**BILLING INFORMATION**

We are pleased to be able to be a part of your medical care. Dr. Michael Ederer is the provider of services that you have received. If you should have and questions and/or concerns regarding the billing of these services, please contact out billing agency listed below. **DO NOT** call your referring physician's office for information about your bill. Neither the referring physician nor his/her staff are affiliated with our billing agency.

If you have insurance, it is your responsibility to provide us with accurate and current information. It is also your responsibility to obtain pre-certification, certification and verification of your insurance benefits and to understand your plan's current benefit and coverage rules. Your insurance will be billed promptly and you will be billed for the balance. **Any balance due from prior services must be paid in order to receive further treatment.**

**PLEASE NOTE- COPAYS AND DEDUCTABLES ARE DUE AT THE TIME OF SERVICE.**

**IF YOU HAVE NO INSURANCE – PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.**

**Billing Agency Information**

Phoenix Healthcare Solutions

Contact – Sara Arthur

Toll Free Number – 866.297.5933

**LAB SERVICES**

All of drug screens are sent to an outside lab for processing. Please let us know before your visit of any issue concerning which laboratory we use. Outside lab services are billed separately and are not part of the visit fee. Any questions concerning the lab’s bill should be directed to the lab.

**INSTRUCTIONS FOR PAIN PROCEDURE PATIENTS**

It is very important to read these instructions carefully. Failure to follow these pre-op instructions could result in having to reschedule your procedure. Most procedures performed by the physician can take up to 5-10 days before you will begin to experience pain relief. It is not uncommon to have an increase in your pain level for the first three days after a procedure. Local Anesthetic is injected with the steroid medication to minimize immediate post-procedure discomfort. The local anesthetic may cause a temporary numbness or tingling sensation following the procedure.

* Do not eat or drink anything for 2 hours prior to having your procedure.
* If you take Coumadin, Plavix, Fish Oil, or aspirin or any medication containing aspirin – notify your physician.

These medications MUST be stopped 5 days prior to your procedure. If you were placed on these meds by your primary care or cardiology doctor, you need to notify them to see if it is safe for you to be off of these medications before stopping them.

* If you take medication for high blood pressure, diabetes, or heart disease and you usually take these meds in the morning, and then take as you normally would at home.
* If you receive oral medication for relaxation and comfort prior to your procedure, take the prescribed medication 30 minutes – 1 hour prior to your scheduled procedure as you will not be able to drive for the rest of the day.
* X-ray will be utilized during your procedure. Please notify your doctor if you are pregnant or think you may be pregnant.
* If you had an epidural block, the numbing medication may last 4-8 hours.

Notice of Privacy Practices

Effective 04/14/2003 Updated 09/23/2013

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

Each time you visit a physician, hospital, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. Your record represents Protected Health Information (PHI).

We are committed to treating and using PHI about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice applies to all PHI, as defined by federal regulations, which is generated by our office.

THE FOLLOWING CATEGORIES DESCRIBE EXAMPLES OF THE WAYS WE USE AND DISCLOSE HEALTH INFORMATION.

For Treatment: We may use your health information to provide you with medical treatment or service. We may disclose medical information about you to other health professionals who contribute to you care (such as doctors, nurses, technicians, or other personnel who are involves in taking care of you).

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company, or a third-party payer. For example, we may need to give your insurance company information about your treatment so they will pay us for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it, unless you exercise your right to restrict. \*\*

For Healthcare Operations (Business Associates): There are some services provided in our office through contracts with business associates. Examples include transcription of your dictated health information, a copy service making copies of your health record, e-Prescribing service, a person who provides data transmission services, computer software vendor, and subcontractors that create, receive, maintain or transmit your medical information on behalf of the contracted Business Associate as required by Omnibus HIPAA Rule compliance. When services such as these are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information as required by HIPAA regulations.

Communication with Family and Friends: We may release medical information about you to a friend or family member who is involved in your medical care or who helps pay for your care.

For Research: We may disclose information to researchers when an institutional review board that has reviewed board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

For Research, Marketing, and Fundraising: Our office does not sell your PHI. Any activity for research, marketing, and fundraising requires your written authorization.

We may also use and disclose medical information to/for the following:

* to remind you that you have an appointment
* Public Health Authorities
* to assess your satisfaction with our services
* Worker's Compensation Agent
* Food and Drug Administration
* Legal Authorities
* Organ and Tissue Donation Organizations
* Military Command Authorities
* Health Oversight Agencies
* National Security & Intelligence
* Funeral Directors, Coroners, Medical Directors
* Protective Services for the President of the United States
* to notify or assist in notifying a disaster relief entity so that your family can be notified about your health status
* for law enforcement purposes as required by law on in response to subpoena

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of this office, you have the right to:

Inspect and Copy: You have the right to view your PHI, obtain a copy of the information, or both. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We are allowed to charge you for these copies. If capabilities exist, you may request access to your medical records in electronic form.

Amend: If you feel that medical information is incorrect or incomplete, you may ask us to amend (not change) the information. We may deny your request for an amendment; and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request a list of certain disclosures we make of you medical information for purposes other than treatment, payment, or healthcare operations.

Request Restrictions: You have the right to request a restriction of limitation on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree to the requested restriction, it will be honored with the exception of permitted disclosures, including emergency treatment, public health authority, Food & Drug Administration, work-related injury, and OSHA compliance.

\*\*Restricted Disclosure: You have the right to restrict disclosure of your personal protected health information to your health plan/insurance company if that information pertains solely to healthcare for which you (or a person on your behalf) paid for the testing or treatment in full, out of pocket. You must continue to pay out of pocket for subsequent care related to restricted disclosure.

Genetic Information: Your genetic information is treated as PHI. It cannot be used to discriminate against you for the provision of health insurance or for underwriting purposes.

Request Confidential Communications: You have the right to request that we communicate with you about medical matter in a certain way or at a certain location (for example, at work, or by U.S. Mail). We will grant this request only if it is submitted in writing. We reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response.

Breach: You will be notified within sixty days if a reportable breach of your PHI occurs.

A Paper Copy of this Notice: You may ask us to give you a copy of this Notice.

If you have any questions about this Notice, please contact our Privacy Officer at this office, telephone 850-279-4417.

We reserve the right to change this notice and to make new provisions effective for all PHI we maintain from the first date of your health record. The current notice will be posted and include the effective date.

If you believe your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer in our office at1001 W. College Blvd, Suite H, Niceville, Fl 32578.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You may revoke your permission to use of disclose medical information about you, in writing, at any time. If you revoke your permission, we will no longer disclose medical information about you for the reasons covered by you written authorization. Please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to you.

**Office Financial Policy and Release of Information**

This document contains the consent to Coastal Anesthesia, P.A. For Financial Responsibility and Assignment of Benefits.

**Patient Acceptance of Financial Responsibility** I request services from Coastal Anesthesia, P.A. On behalf of myself and/or my dependent, and understand that by making this request and accepting said services that I become fully responsible for any and all charges incurred in the course of treatment. I accept the fee charged as a legal and lawful debt and agree to pay said fee, including and/all collection fees (33.33%), attorney fees and/or court costs, if such be necessary.

I understand charges not covered by my insurance company, co-pays, co-insurance, and deductibles are due at the time of my visits as well as any prior balance that I might owe. I also understand that insurance billing is a courtesy provided to me by Coastal Anesthesia, P.A. And I assume full financial responsibility for all charges incurred in the treatment of my medical services. I further understand that failure on the part of the insurer to make payment shall not relieve me of my obligation to pay Coastal Anesthesia, P.A.

I understand it is my responsibility to know the level of benefits provided and what is required by my insurance company in regards to Authorization and Referrals. Our providers are specialists, and may not be in-network with some insurance companies. Many services require prior authorization or referral by the insurance company and/or Primary Care Physician.

I understand that it is my responsibility to contact my insurance company for any referral or authorizations that may be needed along with my in and out-of-network benefits. Coastal Anesthesia, P.A. Will assist me should I have any questions. I understand it is my responsibility to inform this office of any address, telephone number, or name changes. If the office is unable to contact me regarding my bill or should my balance become delinquent, my account may be referred to an outside collection agency.

I agree to pay all reasonable attorneys, collection, or returned check fees in the event of default of payment of my charges or balance arrangements.

**Patient Assignment of Benefits** I assign benefits to be paid by my insurance company directly to Coastal Anesthesia, P.A. Furthermore, should the insurance company issue a check in my name I will notify Coastal Anesthesia, P.A. Immediately and arrange for payment of my balance. Should I cash any check issued by the insurance company meant for reimbursement of services provided to me, I will assume full responsibility of the balance and will pay the balance immediately.

**Authorization for Release of Information** I hereby authorize and agree to Coastal Anesthesia, P.A., disclosing, to the extent allowed by law, my medical and financial records to, a) Any affiliate of Coastal Anesthesia, P.A., billing agents, quality or utilization reviewers; b) Any person or entity to whom I have been referred by Coastal Anesthesia, P.A. For continued care; c) Any physician treating, consulting or otherwise performing services for me, including their employees and agents; d) The Health Care Financing Administration, any governmental or accrediting agency or their agents or employees; e) Any person, entity, or insurance company which may be responsible for all or part of the charges.

**I have read and understand the financial policy and Authorization for Release of Information and agree to its terms.**

**TELEPHONE CONSUMER PROTECTION ACT (TCPA):** You agree, in order for us to service your account or to collect monies you may owe, Coastal Anesthesia, P.A., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic devices, as applicable.