

McCORMICK EYE CENTER
Office of David R. Johnson, M.D.
10619 N. Hayden Road, Suite 101, Scottsdale, AZ 85260
Phone: 480-948-0733

NOTICE OF FINANCIAL POLICY

Payment is required at the time services are rendered. Co-pays, deductibles, and non-covered charges are part of your contract with your insurance company and will **not** be waived. Payment may be made in the form of cash, personal check, debit card, Visa, MasterCard, American Express, or Discover. There is a service charge of twenty-five dollars (\$25) on all returned checks.

If you are a private pay patient or have insurance we are not contracted providers for, you will be required to pay for your office visit and procedure(s) at the time of your visit. We will provide you with an itemized bill. Attach this to your claim and submit to your insurance company for reimbursement.

If we are a contracted provider for your insurance plan, we will submit your claim to your insurance company. If we have not received payment after sixty (60) days, we will request your assistance in collecting payment from your insurance company. Any patient responsibility, not paid at the time of service, is due within thirty (30) days of your insurance company's processing of your claim.

Your insurance contract is between you and your insurance company or companies, and not with the physician. It is your responsibility to know your insurance coverage, contractual status, and excluded services prior to your visit. Your insurance benefits are specified in your contract and your benefits may not be the same as the value of the physician's services.

If your insurance company requires prior authorization and/or a written referral, it is your responsibility to bring the authorization and/or referral to our office. Neither an authorization nor a referral guarantees your insurance carrier will pay for your visit. If you fail to bring the required authorization and/or referral, all charges incurred during your visit become your responsibility. The obligation for payment of service rests with you. Our office does not accept responsibility for collecting on your insurance claim or negotiating a disputed claim.

In the event a surgical procedure is necessary, it is your responsibility to provide our office with all insurance information regarding preauthorization or a second opinion (if required by your policy).

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of David R. Johnson, M.D., may be used and disclosed and how you may access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Our commitment to your privacy.

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but wish to provide you with the following important information.

Use and disclosure of your health information under specific circumstances.

The following circumstances may require us to use or disclose your health information:

1. Public health authorities and health oversight agencies are authorized by law to collect information.
2. Lawsuits in similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or health and safety of another individual or to the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the United States or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal official for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information.

1. You have the right to obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to David R. Johnson M.D., Attention: Kathe Gort, Privacy Officer, 10619 N. Hayden Road, Suite 101, Scottsdale, AZ 85260. Please mail to this address or fax your request to 480-443-5611. Pre-payment is required in advance at ten cents (\$.10) per page plus postage and a handling fee of ten dollars (\$10). Include a phone number in your request where you may be reached to be informed of the fee, which may be paid by credit card, check, or cash. Your medical records will be mailed to you within thirty (30) days of receipt of your payment. If you need medical records interpreted, there will be an additional charge for this service. For information, please call our Privacy Officer, Kathe Gort at 480-948-0733, extension 22.
2. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is held by our practice. You must submit your request in writing to David R. Johnson M.D., Attention: Kathe Gort, Privacy Officer, 10619 N. Hayden Road, Suite 101, Scottsdale, AZ 85260. Please mail to this address or fax your request to 480-443-5611. You must provide us with a reason supporting your request for an amendment.
3. You have the right to a copy of this Notice of Privacy Practices. You may ask us to provide you a copy of this notice at any time. To obtain a copy, contact our front office receptionist. It may be necessary to revise the Notice of privacy Practices. You may contact Kathe Gort, Privacy Officer, at 480-948-0733, extension 22, to request a copy of the most recent revision.
4. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Kathe Gort, Privacy Officer, 10619 N Hayden Road, Suite 101, Scottsdale, AZ 85260. Submit your complaint in writing. You will not be penalized for filing a complaint.
5. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures not identified by this Notice or permitted by law. If a disclosure of your protected health information is made for any reason other than treatment, payment, or health care operations, you have a right to receive an accounting of the disclosure.

If you have questions regarding this Notice of our health information privacy policies, please contact Kathe Gort, Privacy Officer for David R. Johnson, M.D., at 480-948-0733, extension 22.

Please list a phone number or numbers that are best to remind you of your appointments and any lab results.

Home: _____ **Work:** _____ **Cellular:** _____

To whom may we disclose information regarding your care or the payment of your care?

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

I certify I have read the financial and privacy policies of David R. Johnson, M.D. I authorize medical care and accept financial responsibility for any member of my family who is a minor. I authorize payment of medical and/or government benefits to the physician or supplier for any service. I authorize the release of medical information necessary to process a claim, including release to the Arizona Department of Insurance or its duly authorized representatives for the Department's investigations of any claims filed under my policy. I understand I am responsible for ensuring all bills are paid within sixty (60) days of my visit. I understand I am also responsible for all charges regarding my medical care and any collection and/or necessary legal costs will be charged to me in the event my account is not paid in full as described above. If I make payment in the form of a check, and my check is returned for any reason, McCormick Eye Center is authorized to debit my account for the face amount of the check plus a service fee of twenty-five dollars (\$25).

Signature: _____ **Date:** _____ **Account:** _____

Note to signer: If you are not the patient, but the guarantor for a relative or have power of attorney for this patient, please print your name and relationship to the patient. A copy of the power of attorney form is required for our files.

Printed Name: _____

Relationship to patient: _____