Netter J. Ortiz, M.D., P.L.L.C.

WELCOME TO OUR PRACTICE

Dear Patient,

We are pleased that you have chosen Netter J. Ortiz, MD., P.L.L.C., the office of Netter J. Ortiz, M.D., as your healthcare providers. We know that you have a choice in healthcare, and we appreciate your trust.

During your visit, you will be seen by a physician who will do their best to spend the necessary time needed to answer all of your questions. In return, we ask that you communicate with us openly so that we may serve you adequately.

We attempt to see our patients at their scheduled appointment time; however, complications may arise that may delay your appointment. We will do our best to inform you of such situations. We ask patients to be in the office on time. Patients who arrive late, will be rescheduled.

Our practice strives to be at the forefront of healthcare technology. Because medicine and healthcare are constantly changing, we seek continuing education that focuses on the latest advances in healthcare. For instance, our physicians have 24-hour accessibility to your healthcare record via our EMR (Electronic Medical Records) system. Our Patients are able to retrieve their lab results via our secure online "Patient Portal", as well as update their medications, medical history and view their examination summary notes. For patients that are interested, we also have a "text messaging" appointment reminding system available.

As part of our commitment to our patients, our staff is expected to provide you with courteous, respectful service at all times. All staff members are committed to ensuring safe and confidential care at all times. We are bound by Privacy laws and we take Confidentiality seriously. We hold all staff members to the highest expectations in securing your health and personal information. We honor all patients' rights to privacy and ask that you understand our strict adherence to these policies. Please keep in mind that privacy laws and rules were made to protect "you" the patient and we will not violate the law intentionally.

We will not release PHI (Personal Health Information) to family members, spouses, or parents unless there is a signed consent on file, or applicable laws that require us to do so. If you wish for us to provide information about your medical condition to someone else, you must complete the necessary release of information forms.

The following pages contain important information regarding our practice, business operations and requirements for our patients, including forms that we require you complete in order for us to provide services. We require completion of these forms at least five business days prior to your visit to allow us time to verify benefits and request medical records if necessary.

Please read our policies carefully as you will be acknowledging that you have read them thoroughly and that you fully understand them. If you should have any questions, please do not hesitate to contact our Patient Services Coordinator for clarification. Should you ever have any concerns, please do not hesitate to ask for our Practice Administrator.

Please visit our website for additional information at: www.netterjortizmd.com

Thank you,

Netter J. Ortiz, M.D.,P.L.L.C.

PRACTICE INFORMATION & POLICIES

LOCATION

Our office is located at 2100 Village Center Drive, Suite F1, Brownsville, TX 78526.

OFFICE HOURS

Monday through Thursday:	9:00 am – 5:00 pm
Friday	9:00 am – 1:00 pm

After-hours coverage is available 24 hours a day for Urgent issues only.

Should you have an urgent health care issue, you may reach us after hours by calling our Main office number (956) 525-7084. Our answering service will take down your information and relay this to the on-call physician who will contact you as soon as possible.
Please contact us during regular business hours for non-emergency matters.
For Emergencies, please call 911.

HOSPITAL PRIVILEGES

Dr. Ortiz maintain privileges at Valley Baptist Medical Center – Brownsville, located at 1040 W. Jefferson Street. Because we provide hospital services ONLY at Valley Baptist Medical Center in Brownsville. Please be aware that if you go to another hospital or facility, we will not be able to provide services to you.

COVERAGE DURING ABSENCE

In the event that Dr. Ortiz is unable to provide medical coverage for any reason, our office provides additional coverage with Dr. Jesus Roberto Ortiz.

PRESCRIPTIONS AND PRESCRIPTION REFILLS

- All "new" patients must be seen before a prescription will be written or ordered.
- All new problems require a visit prior to any prescription.
- **We do not provide prescriptions refills for patients that are non-compliant with their treatment and or visits.**
- Refills are sent electronically to the pharmacy of choice only when a current treatment plan exists.
- Please make sure to ask about your refill during your visit.

IDENTITY PROTECTION

- We are obligated to protect our patient's identity.
- All patients are required to present a "government issued photo ID". There are no exceptions to this rule.
- Your Insurance company Requires that we identify you via a government issued identification.
- Should you fail to bring a photo I.D., you will be rescheduled.

PATIENT PORTAL

- Our patient portal provides you with access to your lab results, medical records and visit summation. You may log in at any time to review your Electronic Medical Record.
- To reduce waiting time prior to your visit, please log in to our patient portal and update your medical history. Be sure to include all your medications.

PRACTICE INFORMATION & POLICIES

CHILDREN, FAMILY MEMBERS & VISITORS

We LOVE children! However, having children present during an examination presents multiple problems for both the patient and the physician. Safety, privacy and poor communication are just a few of the concerns. If you arrive with children and no one to care for them during your exam, you will be rescheduled.

We want to provide our undivided attention to your care and having a child present may cause unnecessary distractions for both you and your physician, which may cause you unnecessary risk or even injury.

While we do our best to provide a safe environment, it only takes a second for an injury to occur. We do not have babysitting services or the environment to allow children to wait during your visit.

Further, we will not accept responsibility for supervision of your child, or any injury caused by such circumstances.

IMPORTANT – Please understand that by allowing someone to be present during your care, you are allowing them full access to your *private health and financial information*. In these circumstances, we cannot ensure privacy and do not accept responsibility for any breaches in confidentiality related to your personal health information or personal financial information.

Privacy during exam

Due to privacy concerns, we do not allow more than one person to accompany the patient in to the exam room. Additionally, realize that if you allow someone to be present in the exam room, you are giving us authorization to discuss your personal health information in front of this individual.

Visitors, Family Members

We do not allow more than one individual to accompany the patient to their appointment. If you bring more than one individual with you, they will be asked to wait outside.

CELL PHONES & CAMERAS

- **To PROTECT your privacy and that of ALL patients, we do NOT allow cell phone usage in our office.**
- **To PROTECT your privacy and that of ALL patients, we do NOT allow photographs, video or audio recordings to be taken.**
- **Absolutely no Photos, Video or Audio may be taken on the premises without the express written consent of the Administration of Netter J. Ortiz, MD, PLLC.**

Contact Confirmation, Financial & Medical History Updates – One week prior to your visit

We will call to confirm your appointment one week in advance as a courtesy reminder. This is to confirm that your contact information is up to date and to advise you of your financial responsibility prior to your visit. If you need to make any changes to your contact information, financial information, or your medical history, this is the time to advise us. You can also update and complete your medical history via our patient portal prior to your visit to shorten the time you spend with the clinical staff as they take your history.

Appointment Confirmation – Day before your visit

One day prior to your appointment, we will call again to confirm your visit.

We must receive a confirmation from you the day before your scheduled appointment; otherwise, your appointment will be cancelled.

We are available 24/7 via our answering service where you may leave a message to confirm your appointment if we are unavailable.

Disconnected numbers, return mail, wrong numbers

If we are unable to reach you due to wrong numbers, disconnected phone numbers or return mail, we will cancel your appointment**. It is your responsibility to inform us of any changes to your contact information.**

PATIENT & PROVIDER RIGHTS

OUR RIGHTS

- We are a private practice and as such reserve the right to accept you as a patient.
- Patients, family members or visitors who are aggressive or disruptive will be dismissed.
- Patients who are non-compliant with their plan of care may be dismissed.
- Patients who are non-compliant with their appointments or who repeatedly miss, cancel, or reschedule appointments may be dismissed.
- Patients who attempt fraud, violence or coercion of any kind will be dismissed.
- Patients, family members or visitors who are rude or disrespectful to any member of our practice will be dismissed.
- Patients who fail to meet their financial responsibilities may be dismissed.
- We expect full disclosure from our patients for their medical information. Patients who intentionally withhold vital health information may be discharged.

YOUR RIGHTS

- To be treated with dignity and respect.
- We will communicate with you honestly.
- You have the right to be informed about the procedures, treatments and costs involved for services you may receive in this practice. If you have questions, please do not hesitate to ask.
- If you have a complaint, we will investigate the matter and do our best to resolve any problems or concerns you may have.
- We will make every effort to communicate with you effectively, efficiently, and timely.
- We will make every effort possible to provide you with the best healthcare possible.
- You have the right to make informed decisions about your healthcare, and we want to ensure that your choices are informed. Please, do not hesitate to ask about anything you do not understand.
- You have the right to deny any services being offered to you.
- We will respect and maintain your right to privacy.

FINANCIAL POLICIES

INSURANCE, MEDICAID, MEDICARE OR OTHER 3RD PARTY PAYORS

IMPORTANT - Our financial agreement is with you the patient, not the insurance company. Accordingly, we will bill your insurance out of courtesy, not requirement. Your insurance plan pays based on the plan coverage you have, not according to our guidelines. Accordingly, your plan will provide you with the same Explanation of Payment (EOP) that we will receive, which will clearly define your financial responsibility.

Disclaimer: When we contact your insurance to determine what benefits you have, they will automatically give us a disclaimer that states, "Benefits provided, are not a guarantee of payment". This means that they can decline payment at any time – even if they approved it. ***If this occurs, you must understand that you are responsible for payment in full for all services rendered.***

If you wish to appeal this matter with your carrier, we will gladly provide you information and a statement, but we will not appeal services that are deemed as non-covered by your carrier – this is between you and your insurance carrier.

Services that are not paid for and later become the responsibility of the patient, require immediate payment in full. Once you have paid your account, you may then take your time to appeal any nonpayment issues with your insurance carrier. Services rendered are due in full at the time of service; therefore, appeals do not cover non-payment.

PAYMENT RESPONSIBILITIES FOR PATIENTS WITH INSURANCE

With "verified" benefits, and as required by our contractual agreements with insurance companies, we MUST collect all co-pays, and all amounts that are applied to co-pays, deductibles, or patient-out-of-pocket portions (co-insurance).

Without "verified" benefits, we require payment for all services in full. If we are unable to determine benefits prior to your visit, your services will be estimated and must be paid prior to services rendered.

DEDUCTIBLES, CO-PAYS, OUT OF POCKET EXPENSES

Contractual obligations, accepting assignment, in-network participation, and State and Federal laws (dependent on your plan) require that we collect all co-payments, patient portions, co-insurance responsibilities and deductibles. Please do not ask us to defer this or make payment arrangements. These are rules established by "your" insurance company and we must abide by them.

All portions of co-pay's, deductibles, non-covered services, co-insurance and amounts applied towards deductibles are due prior to services being rendered.

PAYMENT RESPONSIBILITIES FOR CASH OR SELF PAY ACCOUNTS

Payment is due prior to services rendered. We accept cash, credit cards, checks and debit credit cards for your convenience. All checks received in this office are submitted electronically for immediate deduction. We do not accept postdated checks

NO INSURANCE COVERAGE DISCOUNT

We offer a 20% discount to the uninsured. All services must be paid in full at the time of service to receive said discount. We do not offer payment plans for cash or self-pay accounts. If you later present with insurance, we will not go retroactive.

REFUNDS AFTER BECOMING ELIGIBLE FOR THIRD PARTY BENEFITS

We will not refund accounts previously paid as a self-pay or cash account under any circumstances should you later provide insurance information or become Medicaid eligible.

FINANCIAL POLICIES

MEDICAID BENEFITS

IT IS YOUR RESPONSIBILITY TO MAINTAIN YOUR MEDICAID BENEFITS. We will not be held responsible for patients who fail to renew their Medicaid. If your Medicaid coverage lapses, your account will immediately become a self pay/cash account and you will be responsible for all services rendered from the date of lapse in coverage. We will NOT accept Medicaid retroactively. We will not refund money for paid services during lapses in coverage. We will only accept Medicaid from the point where you provide us with renewed coverage.

For patients who start out with Private Insurance or as a Self Pay/Cash Account, be advised that we do NOT provide refunds for care provided on a cash basis to patients who later qualify for Medicaid or other third-party assistance or insurance. Patients accounts must be paid in full, up to the current date of service before any new coverage terms or financial arrangements will be considered.

If you plan to apply for Medicaid, be advised that we will only accept Medicaid from that point forward and ONLY if your account is current.

We will NOT look up your Medicaid account, as it is your responsibility to provide us with your card. We will only accept Medicaid from the point where you actually bring us your card. We will not bill retroactively. We will only accept benefits if the account has been paid in full through that prorated month. Please speak with our Billing Department for a written proposal on services and other details.

FORMS & COPYING MEDICAL RECORDS

Forms: There is a $25.00 fee for completion of each Disability, FMLA, supplemental benefit coverage form, or any other form that requires the physician's signature and review. Should medical records be required, an additional fee (see below Medical record fees) for medical records will be charged.

Medical Records: For copies of medical records, there is a base fee of $25.00. This fee covers up to the 20th page. Additional pages will be charged at .50 cents each. Additional fees include labor and supplies, which will be prorated, based on time and quantities used. These fees are in accordance to Texas Medical Board rules §165.2.

Keep in mind that you have full access to your medical records in the patient portal.

RETURNED CHECK POLICY & UNAPPROVED DEBITS/CREDIT TRANSACTIONS:

NSF checks or other returned items (regardless of method of payment) will require reimbursement in the form of cash, or certified funds, plus a $45.00 fee. Any item not paid and resolved in full within 15 days will be pursued via the Attorney General's office and prosecuted by this office.

☙ ☙ FRAUD WARNING: MEDICAID, MEDICARE, PRIVATE INSURANCE ❧ ❧

Medicaid is considered the payor of last resort for medical expenses (Texas Administrative Code 42 CFR §358.219). This means that you must exhaust all private insurance responsibilities before utilizing State or Federal funds.

In accordance to Federal Law (42 CFR §§433.138 – 433.148), **all Medicaid recipients must report any Private Insurance to Medicaid.** As a condition of Medicaid eligibility, a person must:

- cooperate in providing any Third-Party Resource (TPR) information to HHSC; and
- agree to the assignment of rights (AOR) of any TPR benefits to HHSC.

Additionally, all health care providers are required to notify the Texas Health & Human Services Commission of fraud when private insurance is discovered but not disclosed by the patient.

What this means to you:

If you have Medicaid and private insurance but fail to disclose this information to Medicaid or our office, this is considered fraud of the Medicaid program, which is a State, and federally funded program. Fraud under these programs is punishable by law.

Should we discover that you failed to disclose this information, we are required by law to notify TX DHHS. We will cooperate with authorities in all fraud instances.

We are required to refer the person for fraud if the person:

- fails to report any TPR coverage or liability; or
- does not reimburse HHSC when a third-party payment for medical services is received and the expenditure is one hundred dollars or more.

In instances where Medicaid recovers payments from our office, the Patient is liable for the account balance, which is due immediately.

ACKNOWLEDGEMENT

I _____ have read and understood the information and policies above and agree to adhere to them. It is further understood that if I commit fraud, my provider is required to report such instances to the proper authorities.

Patient Signature:_____ Witness:_____

Date:_____ Date:_____

Netter J. Ortiz, M.D., P.L.L.C.

Date:_____

Patient Information		Please check one: [ ] New Patient [ ] Update Info		
Name	SS#	Marital Status [ ] S [ ] M [ ] D [ ] W	Sex [ ] M [ ] F	Birth date
Address		Home Phone:		Cell Phone:
City:	State:	Zip:		Driver's License:
Employer	Address (include city, state & zip)	Work Phone:		Occupation:
Emergency contact (Name, relationship, and phone number)				Referred by:
Responsible Party/Guardian Information *				
Name	SS#	Marital Status [ ] S [ ] M [ ] D [ ] W	Sex [ ] M [ ] F	Birth date
Address		Home Phone:		Cell Phone:
City:	State:	Zip:		Driver's License:
Employer	Address (include city, state & zip)	Work Phone:		Occupation:
Insurance Information * Please present insurance cards to receptionist in addition to completing the area below.				
*** Primary** Insurance: Company Name		Identification Name		Group #
Insurance Company address (include city, state & zip)				
Name of Policyholder		Date of Birth	Relationship to patient	
***Secondary** Additional Insurance: Company Name		Identification Name		Group #
Insurance Company address (include city, state & zip)				
Name of Policyholder		Date of Birth	Relationship to patient	

Additional Information	**Office use only**
Were you injured on the job? [ ] Yes [ ] No If yes, date of injury ___/ ___/ ___ Were you injured in an auto accident? [ ] Yes [ ]No If yes, date of injury ___/ ___/ ___ Injuries:	[ ] Self-pay patient (collect @ time of service) [ ] MCD patient (verified day before) [ ] Insured patient (collect co-pay & deductible) [ ] MCDR patient (collect patient portion)
Chart Number:__ __ __ __ __ __ __ __ Medical Record #_____	[ ] TX DL [ ] TX ID [ ] Scanned? [ ] Passport [ ] Other ID [ ] In patient acct? Vfy By: _____ Date: _____

ACKNOWLEDGEMENT

I attest that I am the patient or the patients' legally appointed and authorized guardian; and the information given by me for Netter J. Ortiz, MD., PLLC, is true and correct. I further acknowledge that the information provided in these documents may be used for the purpose of billing and receiving payment under Medicare and/or Medicaid programs, and or private Insurance plans, which are protected by Federal and State laws. I understand that falsification of this information is considered fraudulent and is subject to protection under these laws. By signing this agreement, I am declaring all information true and accurate.

_____ ____/ ____/ ____ _____ ____/ ____/ ____

Patient/Guarantor signature Date Witness Date

GOVERNMENT QUALITY PROGRAM PARTICIPATION

As part of the governments Meaningful Use program and the Physicians Quality Reporting System, our practice is actively participating in recording patient Demographic Information. This information is reported only as a numeric outcome and there is no identity attached to the data.

Please choose your Ethnicity, Race and Language preference below.

Ethnicity

[ ] Hispanic or Latino
[ ] Not Hispanic or Latino
[ ] Unknown

Race

[ ] American Indian or Alaskan Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian or other Pacific Islander
[ ] White
[ ] Unknown
[ ] Other race: _____

Language Preference

I prefer to communicate in the following language:

Writing: [ ] English
[ ] Spanish
[ ] Other Please specify:_____

Verbal: [ ] English
[ ] Spanish
[ ] Other Please specify:_____

GENERAL CONSENT FOR TREATMENT

Patient's Name: _____

The following is a general consent for treatment of services rendered by Netter J. Ortiz, MD., PLLC, which may include diagnostic, radiology and laboratory procedures and the administration of medication. Should you require additional treatment and procedures, we will discuss said treatment and options with you, and obtain consent prior proceeding.

I, knowing that I am in need of examination or treatment, do hereby voluntarily consent to such procedures and medical care provided to me by the physicians of Netter J. Ortiz, MD., PLLC, or their designee as necessary.

I further acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the result of treatments or examinations by Netter J. Ortiz, MD, PLLC, PLLC or its representatives.

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of medical and surgical benefits to Netter J. Ortiz, MD, PLLC, PLLC, its physicians or designees under their supervision, for services rendered to me. I understand I am financially responsible for all the fees or remaining balances not covered by my insurance or third-party payor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any medical or other information necessary to process claims in accordance with the Health Information Patient Portability Act.

POLICY ACKNOWLEDGEMENT AND RECEIPT

I have been provided the following information and I am aware that I may ask questions regarding the information received.

1. Pg #1: Welcome to our Practice (general practice information)
2. Pg #2-3: Practice Information & Policies
3. Pg #4: Patient & Provider Rights
4. Pg #5-6: Financial Policies
5. Pg #7: Medicaid Medicare Fraud Warning
6. Pg #8: Patient Demographic Sheet
7. Pg #9: Government Program Notice
8. Pg #10: Consent to Treat and Policy Acknowledgement

You will retain copies of pages 1-6, we will keep pages 7-10 in your permanent record as acknowledgement that you have read, understood, and agree to our policies.

Signed: _____ Date: _____
Patient or Guardian

Witness: _____ Date: _____