MANSFIELD
F·A·M·I·L·Y
PRACTICE
A LIMITED LIABILITY COMPANY

Patient Expectations and Payment Policy

Patient Expectations

We believe the best healthcare outcomes are based on mutual trust between patient and physician. We believe patients and families are partners in ensuring that the best possible care is provided in a healthful, safe environment. **We count on you to participate in your care in the following ways:**

- To the best of your knowledge, provide accurate and complete information about your present symptoms, past illnesses, allergies, hospitalizations, medications and other matters relating to your health.
- Ask questions if you do not clearly understand the proposed plan of care and what is expected of you.
- Arrive at least 10 minutes before your appointment to ensure you are seen on time.
- Keep appointments. When you are unable to do so for any reason, notify the office reception staff in advance. A **$25** fee may be applied for any visit missed without proper notice. Excessive missed appointments may result in discharge from the practice.
- Treat other patients and staff with consideration and respect.
- Be respectful of other patients' right to privacy.
- Be honest with the doctors & other health-care workers.
- Follow the treatment plan agreed upon.
- Provide accurate insurance information and promptly pay balances not covered by your insurance.
- Understand the requirements of your own health insurance. (We will do our best to assist you as we are able however, it is virtually impossible for us to keep all of the different health plans straight, but we sure try!)
- Pay your co-payment at the time of your appointment.
- Understand how your pharmacy plan works.
- If you have a life threatening situation, call 911 or go to the nearest emergency room.

Mansfield Family Practice will try to do everything we can to accommodate you and your family. **In an effort to set reasonable expectations, Mansfield Family Practice will:**

- Introduce ourselves.
- Greet you in a pleasant, professional manner.
- Take you to a neat, orderly exam room and be prepared for your exam.
- Answer your questions or let you know where you can get answers.
- **Fill or refill prescriptions within twenty-four (24) hours**. Refills may take longer if they are called in afterhours or on weekends.
- Process any requested forms you may need for school/camp physicals, disability, FMLA, etc. within 7 days. **A form completion fee may apply of $25**

- Do our best to find you a suitable appointment date and time. *Please note that most forms you need for schools or work require an examination*
- Provide prompt and accurate billing
- Keep all your records and communications concerning care and treatment confidential.
- Handle routine medical questions during normal business hours. Every effort will be made to return your call in a timely manner, however, *you may need to be seen in our office to properly diagnose and treat a problem.* We can only truly treat all medical problems in person.

Payment Policy

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

- **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

- **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

- **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

- **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

- **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

- **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

- **Nonpayment.** If your account is past due, you will receive a letter stating that your account may be heading to collections. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail.

- **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

- **Form Completion Fee.** We require payment for the completion of forms done on your behalf outside of an office visit. These charges are to be paid at the time of service

Mansfield Family Practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the patient expectations and payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

_____ _____

Name **Date of Birth**

Thank you for choosing Mansfield Family Practice for your health care needs. We are pleased to have you as a patient.

MANSFIELD FAMILY PRACTICE

Physician (circle): Dardick Madraswalla Winakor Hughes

First Name:	Gender/Gender Identity:	
Middle Initial:	Date of Birth:	
Last Name:	Marital Status: M S D W O (circle)	
Mailing Address:	Race/Ethnicity:	
	☐ I decline to answer Race/Ethnicity	
	E Mail address:	
Home Phone:	Pharmacy:	
Cell Phone:	Pharmacy Town:	
Work Phone:	Emergency Contact Name:	Phone:
Previous Primary Care Provider:	Emergency Contact Relationship:	

INSURANCE INFORMATION (A COPY OF YOUR CARD(S) IS REQUIRED FOR OUR RECORDS)

If you have no insurance, check here _____ (Payment will be required at the time of service)

Primary Insurance:	Secondary Insurance:
Employee/Policy Holder's name:	Employee/Policy Holder's name:
Date of Birth:	Date of Birth:
Policy holder address:	Policy holder address:
Insurance ID #:	Insurance ID #:
Group #:	Group #:
Policy Holder's Employer:	Policy Holder's Employer:

Other family members (including parents and legal guardians):

Name and Relationship:	Date of Birth:	Name and Relationship:	Date of Birth:

I request that payment of authorized Medicare & Insurance benefits be made on my behalf to my Physician or covering provider at Mansfield Family Practice, LLC. I confirm that all of the information I have entered is accurate and accept the responsibility of payment for services rendered that are not covered by my insurance plan.

Patient/Guardian Signature Name Date

MANSFIELD
F A M I L Y
PRACTICE
A LIMITED LIABILITY COMPANY
34 PROFESSIONAL PARK ROAD
STORRS, CONNECTICUT 06268
TEL: (VOICE) 860/487-0002
(FAX): 860/429-1663

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I _____ hereby authorize all medical service sources and health care providers to use
Patient Name
and/or disclose the protected health information ("PHI") described below.

2. Authorization for release of PHI covering the period of health care (check one)
- ☐ from (date) _____ - to (date) _____ OR
- ☐ All past, present and future periods.

3. The following information needs a separate consent to be Used or Disclosed. Please indicate your authorization by checking each item.

☐Consent to ☐Refuse Mental health records
☐Consent to ☐Refuse Communicable diseases (including HIV and AIDS)
☐Consent to ☐Refuse Alcohol/drug abuse treatment
☐Consent to ☐Refuse Other (please specify): _____

4. In addition to the authorization for release of my PHI described in paragraphs 2 and 3 of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name(s):_____ Relationship(s):_____
_____ _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____ , (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I acknowledge I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

10. I acknowledge I have received and/or reviewed a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact the Practice Administrator.

11. I understand that the PHI disclosed under this authorization may be subject to redisclosure by the recipient

and no longer protected under federal privacy regulations. I also understand that if the PHI that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, Mansfield Family Practice, LLC may not redisclose that information under Connecticut State Law.

I acknowledge that I have carefully reviewed this Authorization and understand its provisions. If you would like to receive a copy of this executed agreement please enclose a self addressed stamped envelope.

_____ _____

Signature (Patient or legal guardian) Date

_____

Print Name (Patient or legal guardian)