PATIENT PRACTICE GUIDELINES

DISCLAIMER: PLEASE READ ALL PORTIONS OF PATIENT-PRACTICE GUIDELINES. UPON READING, ACKNOWLEDGING AND SIGNING THESE PATIENT-PRACTICE GUIDELINES YOU WILL BE HELD ACCOUNTABLE FOR UPHOLDING AND ABIDING BY THESE GUIDELINES. THANK YOU FOR YOUR COOPERATION.

WELCOME:

THE INTERAMERICAN DIABETES & ENDOCRINOLOGY STAFF ARE ALL HAPPY TO HAVE YOU AS A PATIENT. YOU HAVE BEEN REFERRED TO US BY YOUR PRIMARY CARE PROVIDER SO THAT WE MAY COLLABORATE IN YOUR MEDICAL CARE. DR. ALVAREZ SPECIALIZES IN DIABETES AND ENDOCRINOLOGY AND AS A SPECIALIST, HE TAKES EXTRA CARE TO VIEW EACH PATIENT'S CASE INDIVIDUALLY AND COME UP WITH A TREATMENT PLAN. YOU ARE THE MOST IMPORTANT PERSON IN THIS PRACTICE AND YOUR WELFARE IS OUR PRIORITY SO PLEASE FEEL FREE TO ASK QUESTIONS DURING YOUR VISIT OR THROUGH ALL POSSIBLE CHANNELS OF COMMUNICATION.

REACH US AT:

FRONT OFFICE/SCHEDULING

PHONE: (706) 507-7067 - EXT 403, 404, 412

EMAIL: info@iaendo.com frontoffice@iaendo.com

CLINICAL TEAM/MEDS

PHONE: (706) 507-7067 - EXT 408, 414

EMAIL: nurseone@iaendo.com

BILLING OFFICE

PHONE: (706) 507-7067 - EXT 406, 407

EMAIL: billingmain@iaendo.com

OFFICE ADMIN

PHONE: (706) 507-7067 - EXT 405

EMAIL: manager@iaendo.com

DR. ALVAREZ

EMAIL: dralvarez@iaendo.com

ANSWERING SERVICE (AFTER HOURS)

PHONE: (706) 507-7067

FINANCE/BILLING:

- WE MUST COLLECT ESTIMATED CO-PAYS AND/OR DEDUCTIBLES AS REQUIRED BY INSURANCE COMPANIES AND GEORGIA STATE LAW.

- YOU ARE ULTIMATELY RESPONSIBLE FOR ALL UNPAID FEES FOR SERVICES RENDERED, IT IS ULTIMATELY **YOUR** RESPONSIBILITY TO MONITOR AND TO MAINTAIN THE STATUS OF YOUR INSURANCE POLICY

- **REFERRALS ARE THE RESPONSIBILITY OF THE PATIENT**; THE PATIENT MUST MONITOR AND BE AWARE OF ANY CHANGES TO THEIR REFERRAL. WE MAY NOT BE ABLE TO SEE YOU WITHOUT A REFERRAL SO PLEASE HAVE ONE FROM YOUR PCP, INSTITUTION OR INSURANCE IF REQUIRED.

- PLEASE **ENSURE THAT ALL BILLING INFORMATION IS CORRECT. INSURANCE COMPANIES WILL DENY/REJECT CLAIMS DUE TO INCORRECT DEMOGRAPHIC INFORMATION. APPEALING CLAIMS TAKES ADDITIONAL TIME AND STAFF, THEREFORE YOU MAY BE CHARGED A MINIMAL FEE FOR SUBMITTING ERRONEOUS BILLING INFORMATION THAT LEADS TO A BILLING APPEAL.**

- PAYMENT IS DUE ON THE SAME DAY THAT SERVICES ARE RENDERED. WE ACCEPT CASH, DEBIT, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. CASH ACCOUNTS ARE COLLECTED UPFRONT.

- IF YOUR INSURANCE COVERAGE IS DENIED, WE WILL BILL THE SERVICE AS PATIENT RESPONSIBILITY FOR YOUR VISIT.

- I HAVE READ THE ABOVE AND UNDERSTAND IT IS MY RESPONSIBILITY TO MAKE SURE ALL INSURANCE REQUIREMENTS ARE FULFILLED. IT IS ALSO MY RESPONSIBILITY TO NOTIFY INTERAMERICAN DIABETES & ENDOCRINOLOGY OF ANY CHANGES TO MY POLICY/INSURANCE.

INTERAMERICAN DIABETES & ENDOCRINOLOGY WILL ACCEPT THE FOLLOWING INSURANCES:

AETNA AETNA MEDICARE ADVANTAGE AMBETTER AMERIGROUP BCBS CARESOURCE CHAMPVA CIGNA CLOVER HEALTH HUMANA MEDICAID MEDICARE OSCAR HEALTH PEACHSTATE TRICARE EAST TRICARE FOR LIFE UNITED HEALTHCARE UMR WELLCARE OSCAR HEALTH MONTGOMERY VAMC

I CERTIFY THAT MY INSURANCE INFORMATION IS CURRENT AND ACCURATE; I AUTHORIZE ASSIGNMENT OF INSURANCE BENEFITS TO RICARDO ALVAREZ M.D. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHANGES WHETHER OR NOT PAID BY INSURANCE. I

AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. RICARDO ALVAREZ, M.D. AND THEIR REPRESENTATIVES MAY USE MY HEALTHCARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE GIVEN INSURANCE COMPANIES AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR THE SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED.

SIGNATURE: _____ DATE: _____

NAME: _____

APPOINTMENTS:

- PLEASE ARRIVE ON TIME. CALL OUR OFFICE IF YOU ARE RUNNING LATE. IF YOU ARE MORE THAN 15 MINUTES LATE TO YOUR APPOINTMENT, YOUR TREATMENT MAY HAVE TO BE DELAYED.

- THERE IS A 24 HOUR CANCELLATION NOTICE. THIS ALLOWS THE CLINIC TO FILL YOUR APPOINTMENT TIME. IF THE APPOINTMENT DOES NOT HAVE A 24 HOUR CANCELLATION NOTICE, **THERE WILL BE A $45 NO SHOW FEE.**

- PLEASE BE AWARE, DUE TO THE SPECIALTY OF THIS OFFICE, THERE ARE PATIENTS THAT MAY REQUIRE MORE TIME AND ATTENTION ACCORDING TO THE SEVERITY OF THEIR MEDICAL CONDITION BECAUSE THIS IS THE CASE, WAIT TIMES MAY BE LONGER THAN EXPECTED. **PLEASE PLAN TO SPEND A TOTAL OF 45 MIN - 3 HOURS TOTAL FOR YOUR VISIT** AS OTHER PROCEDURES MAY ALSO BE REQUIRED BASED ON YOUR OWN MEDICAL CONDITION. READING/WORK/ENTERTAINMENT MATERIAL ARE ENCOURAGED.

- **NEW PATIENTS, PLEASE ARRIVE 15 – 30 MINS EARLY** TO FILL OUT THE NECESSARY PAPERWORK. WE ENCOURAGE NEW PATIENTS TO BRING ANY MEDICAL RECORDS THEY HAVE TO INCLUDE: MEDICAL HISTORY, ALLERGIES, SURGICAL HISTORY, FAMILY HISTORY AND CURRENT MEDICATIONS (PLEASE BRING MEDICATION BOTTLES OR UPDATED LIST SO THAT WE MAY BEST SERVE YOU) .
- **FOLLOW UP PATIENTS,** PLEASE ADVISE THE CLINICAL TEAM OF ANY CHANGES IN MEDICATION AND/OR SYMPTOMS. **YOUR LABS SHOULD BE DRAWN AT LEAST TWO WEEKS BEFORE YOUR VISIT** TO ENSURE THE OFFICE RECEIVES THE RESULTS.

- **REFILLS WILL BE SENT AT THE TIME OF YOUR APPOINTMENT**. YOU WILL BE GIVEN ENOUGH MEDICATION TO LAST UNTIL YOUR NEXT FOLLOW UP. IF YOU MISS AN APPOINTMENT OR NEED TO RESCHEDULE, WE MAY PROVIDE A MEDICATION BRIDGE AS A

COURTESY. IF YOUR RX REQUIRES PRIOR AUTHORIZATION THERE MAY BE A SLIGHT DELAY TO RECEIVE THE RX WHILE THE OFFICE WORKS TO GET THE PRIOR AUTHORIZATION APPROVED.

PRACTICE POLICIES:

- I CONSENT THAT IF I RELOCATE, INTER AMERICAN DIABETES AND ENDOCRINOLOGY WILL NOT PRESCRIBE MEDICATION IF I AM UNABLE TO FIND A NEW PROVIDER. IT IS RECOMMENDED TO SCHEDULE YOUR LAST APPOINTMENT THREE DAYS PRIOR TO RELOCATING TO ENSURE YOU HAVE AT LEAST 30 DAYS OF MEDICATION.

- I UNDERSTAND THAT IF I AM GIVEN A HAND WRITTEN PRESCRIPTION, IT IS MY RESPONSIBILITY TO TAKE THAT PRESCRIPTION DIRECTLY TO MY PHARMACY THE DAY IT IS GIVEN. **WE WILL NOT HONOR ANY LOST, STOLEN, OR MISPLACED PRESCRIPTION.** ONCE GIVEN TO YOU, THE PRESCRIPTION WILL BE YOUR RESPONSIBILITY AND YOUR RESPONSIBILITY ALONE. IF THERE IS A CLERICAL ERROR WITH THE PRESCRIPTION DUE TO OUR CLINICAL DEPARTMENT, PLEASE RETURN THE ORIGINAL AND A NEW, CORRECTED PRESCRIPTION WILL BE GIVEN TO YOU.

- I UNDERSTAND THAT INTER AMERICAN DIABETES & ENDOCRINOLOGY DOES NOT RESPOND TO REFILL REQUESTS THAT ARE MADE BY MY PHARMACY.

- I UNDERSTAND THAT MANY MEDICATIONS USED MAY ADVERSELY AFFECT PREGNANT WOMEN AND UNBORN CHILDREN. I CONSENT THAT IF I AM CURRENTLY NOT USING CONTRACEPTIVES, INTEND TO GET PREGNANT OR AM CURRENTLY PREGNANT, I MUST INFORM THE PROVIDER IMMEDIATELY.

- I CONSENT THAT IF I AM NOT SEEN BY INTER AMERICAN DIABETES & ENDOCRINOLOGY AT LEAST **ONCE EVERY 4 MONTHS**, IT IS ASSUMED THAT INTER AMERICAN DIABETES AND ENDOCRINOLOGY WILL NO LONGER BE RESPONSIBLE FROM MY CARE. IF AN APPOINTMENT IS MADE BY THE PROVIDER FOR OVER 4 MONTHS, AN EXCEPTION WILL BE MADE.

- PRIOR AUTHORIZATIONS (PA) ARE NOT PART OF OUR MEDICAL SERVICES BUT RATHER AN EXTRACURRICULAR SERVICE THAT IS OFTEN REQUESTED BY CERTAIN INSURANCES. DEPENDING ON YOUR COVERAGE, INSURANCES WILL ONLY ACCEPT NAMEBRAND/PREFERRED MEDICATIONS WITH A PA. ELECTRONIC REQUESTS SUCH AS “COVER MY MEDS” WILL BE COMPLIMENTARY. SINCE MOST PA TAKES ADDITIONAL TIME AND STAFF, **THERE WILL BE A FEE OF $25 FOR EACH ONE. ANY ADDITIONAL APPEALS FOR THE PA WILL BE $40.**

- I UNDERSTAND THAT INTER AMERICAN DIABETES & ENDOCRINOLOGY DOES NOT HAVE TELEPHONE OPERATORS AVAILABLE 24/7 IN HOUSE. I CONSENT AND UNDERSTAND THAT TELEPHONE CALLS MAY BE HANDLED BY AN ANSWERING MACHINE AND I MAY NEED TO LEAVE A VOICEMAIL. IT MAY TAKE UP TO 48 HOURS TO RECEIVE A CALL BACK.

CODE OF CONDUCT:

THE FOLLOWING IS THE CODE OF CONDUCT EXPECTED FROM ANY OF OUR PATIENTS ADMITTED TO INTER AMERICAN DIABETES & ENDOCRINOLOGY, ANY VIOLATION OF THE CODE OF CONDUCT WILL RESULT IN TERMINATION OF OUR SERVICES AND THE OFFICIAL DISCHARGE OF THE PATIENT AND THE PATIENT WILL NOT BE REINSTATED TO OUR CARE.

- **NO WEAPONS** ARE ALLOWED ON THE PREMISE TO INCLUDE KNIVES, FIREARMS, ETC.
- **NO ILLEGAL SUBSTANCES** ARE ALLOWED ON THE PREMISE SUCH AS DRUGS OR ALCOHOL.
- **NO HARM OR THREAT** SHALL BE MADE TO ANY PATIENT, PROVIDER, OR STAFF MEMBER.
- IF YOU DEMONSTRATE YOUR RAPPORT WITH THE OFFICE IS SO POORLY REDUCED, YOU WILL BE TRANSFERRED TO THE CARE OF ANOTHER OFFICE.
- IF YOU ARE **NOT COMPLIANT** WITH YOUR MEDICATIONS YOU WILL BE DISCHARGED FROM THE PRACTICE. (YOU MAY BE ELIGIBLE FOR REINSTATEMENT IF YOU RECEIVE AND COMPLY WITH EDUCATION ON THE VALUE OF FOLLOWING MEDICATION COMPLIANCE).
- YOU MUST CONTINUE TO SEE THE PROVIDER AT LEAST ONCE EVERY 4 MONTHS. UNLESS YOU ARE DIRECTED OTHERWISE BY THE PROVIDER.
- AFTER 3 NO-SHOW APPOINTMENTS OR CANCELATION YOU WILL BE PLACED AT RISK FOR DISCHARGE FROM THE PRACTICE AND WILL HAVE **1-WEEKS TIME TO RESCHEDULE AND KEEP** AN APPOINTMENT. FAILURE TO DO SO WILL RESULT IN TERMINATION FROM THE PRACTICE.

PATIENT'S RIGHTS:

- THE PATIENT SHALL BE FREE FROM DISCRIMINATION BASED ON AGE, RACE, ETHNICITY, CULTURE, LANGUAGE, PHYSICAL OR MENTAL DISABILITY, SOCIOECONOMIC STATUS, OR SEX. THE PATIENT HAS THE RIGHT TO REFUSE SERVICES.
- PATIENTS WILL BE TREATED WITH DIGNITY AND RESPECT.
- THE PATIENT HAS THE RIGHT TO PERSONAL PRIVACY AND INFORMATION PRIVACY.
- THE PATIENT HAS THE RIGHT TO EXPECT A SAFE AND HEALTHY ENVIRONMENT WHILE AT INTER AMERICAN DIABETES AND ENDOCRINOLOGY.

- THE PATIENT HAS THE RIGHT TO KNOW THE IDENTITY AND PROFESSIONAL STATUS OF INDIVIDUALS PROVIDING SERVICE.

- THE PATIENT HAS THE RIGHT TO OBTAIN COMPLETE AND CURRENT INFORMATION CONCERNING THEIR DIAGNOSIS AND TREATMENT FROM THE PROVIDER.

LAB POLICIES:

- THE PATIENT MUST ARRIVE TO OR COMPLETE THEIR LAB VISITS PRIOR TO A VISIT WITH THE PROVIDER IN ORDER TO PROPERLY RECEIVE FOLLOW UP TREATMENT

- THE PATIENT MAY BE LIABLE FOR PAYMENT OF CERTAIN LABS DRAWN THAT MAY NOT BE COVERED BY THEIR INSURANCE POLICY. THE PROVIDER WILL REQUEST LABS AND TESTING NECESSARY TO PROVIDE THE PATIENT WITH THE BEST MEDICAL CARE. UNFORTUNATELY, INSURANCE COMPANIES WILL OCASSIONALLY DENY A CLAIM FOR LABWORK AND IT IS THE PATIENT'S RESPONSIBILITY TO COMMUNICATE WITH THE INSURANCE ABOUT COVERAGE.

- IF THE PATIENT CHOSES TO HAVE THE LABS DRAWN OUTSIDE OF THE OFFICE, OR OUTSIDE OF LABCORP, **THE PATIENT MUST ENSURE THAT THEY SHARE THE LAB RESULTS WITH THE OFFICE BEFORE THEIR NEXT APPOINTMENT TO ENSURE PROPER FOLLOW UP TREATMENT.**

- SHOULD A PATIENT MISS A LAB APPOINTMENT **IT IS THEIR RESPONSIBILITY TO RESCHEDULE AND GET THEIR LABS** DRAWN AT LEAST **TWO WEEKS PRIOR** TO THE FOLLOW UP VISIT.

- LABCORP IS A SEPARATE ENTITY FROM INTER AMERICAN DIABETES AND ENDOCRINOLOGY, THEREFORE ALL ANY AND ALL LABCORP ISSUES MUST BE RESOLVED WITH LABCORPS, SUCH AS BILLING AND PAYMENTS.

FUNDACION HISPANA A EL NECESITADO (HISPANIC FOUNDATION TO THE NEEDY):

INTER AMERICAN DIABETES & ENDOCRINOLOGY OFFERS FINANCIAL AND MEDICAL ASSISTANT TO THOSE IN NEED THROUGH THE "FUNDACION HISPANA A EL NECESITADO" (HISPANIC FOUNDATION TO THE NEEDY). ANY PATIENT THAT MAY LACK HEALTH COVERAGE DUE TO SEVERE FINANCIAL HARSHIP MAY QUALIFY FOR ASSISTANCE. THIS ASSISTANCE WILL ONLY LAST WHILE THE PATIENT IS IN NEED AND IS DONE SO IN THE HOPES THAT THE PATIENT WILL, IN THE MEANTIME, RECOVER FROM THEIR HARSHIPS.

PRACTICE FEES:

- **$45** NO SHOW FEE
- **$30** MEDICAL RECORDS
- **$25** PRIOR AUTHORIZATIONS (PA) - **$40** PA APPEALS
- **$15** INCORRECT BILLING DEMOGRAPHICS

RELEASE OF INFORMATION:

I GIVE MY CONSENT FOR RICARDO ALVAREZ M.D EMPLOYEES OR ASSOCIATES TO LEAVE MESSAGES ON MY ANSWERING MACHINE OR VOICEMAIL REGARDING MY MEDICAL CARE, TEST RESULTS, APPOINTMENT CONFIRMATION AND PAYMENT ISSUES. I ALSO GIVE THEM PERMISSION TO DISCUSS THESE ISSUES WITH THE FOLLOWING PEOPLE:

Name:_____ Phone:_____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____Phone: _____ Relationship: _____

Name:_____Phone: _____ Relationship: _____

Name:_____Phone: _____ Relationship: _____

OR

[ ] I DO **NOT** GIVE CONSENT TO LEAVE MESSAGES OR VOICEMAILS REGARDING MY MEDICAL CARE, TEST RESULTS, APPOINTMENT CONFIRMATION AND PAYMENT ISSUES.

[ ] I DO **NOT** GIVE CONSENT TO SHARE THIS INFORMATION WITH OTHER PEOPLE.

GENERAL CONSENT FOR TREATMENT

Patient Name: _____ D.O.B: _____ /_____ /_____

- **Consent:** I request and authorize Health Care Services by my physician, and his/her designees as may deem advisable. This may include routine diagnostic, radiology and laboratory procedures and medication administration. I do hereby acknowledge that I am requesting treatment from the provider at Inter American Diabetes and Endocrinology. I understand that the provider may order specific medical procedures as part of treatment. I am aware it is my right to stop treatment at any time. I provide my informed consent to be treated virtually via tele-medicine services.

- **Authorization To Be Photographed:** I agree to be photographed by a staff member of Inter American Diabetes and Endocrinology. I understand that this photography will be attached to my active medical record and will be used for identification purposes only. I also understand that Inter American Diabetes and Endocrinology will ensure and promote the strictest standards of confidentiality and that upon my discharge, this photograph will be retired along with any active records. The record will be made available to you or designee upon your request.

- **Release of Information:** I understand that the confidentiality of all medical records will be protected to the full extent of the law. I am aware that an agent of my insurance company or other third-party payer may be given information regarding cost, dates and/or types of services received. I authorize InterAmerican Primary Care LLC. to release all information from my medical record to:
  Payors, organizations or insurance companies which are responsible, in whole or in part, for filing appeals of denial of benefits, so that the physician may be paid for the services provided to me; and independent auditors or review agencies retained by any third-party payors and provide valuable input, I also authorize InterAmerican Primary Care LLC. to release my demographic information for any type of medical payment/treatment

- **Payment:** I assign and authorize payment, for any and all services rendered, directly to InterAmerican Primary Care LLC. from my insurance company or third-party payor including, but not limited to, Medicare, Medicaid, commercial health insurance, automobile no-fault insurance and workers disability compensation insurance.
  In consideration of the professional services provided or to be provided to me, I agree to pay all charges not covered by my insurance company or any applicable health benefit including, but not limited to, deductibles, co-payments, and non-covered balances. I

understand that it is my personal responsibility to pay InterAmerican Primary Care LLC. all charges for services rendered despite any disputes or disagreements between my insurance company and myself.

- **Valuables:** I understand that InterAmerican Primary Care LLC. is not responsible for valuables or personal articles.

I HEREBY AGREE TO UPHOLD AND ABIDE BY ALL OF THE PATIENT-PRACTICE GUIDELINES. I AGREE TO ANY AND ALL CONSEQUENCES OF DEVIATING FROM ANY OF THE PATIENT-PRACTICE GUIDELINES.

SIGNATURE: _____ DATE: _____