UB|MD
INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

1020 Youngs Rd.
Williamsville, NY 14221
P: 716.961.9900
F: 716.961.9911

1001 Main Street
Buffalo, NY 14203
P: 716.961.9900
F: 716.961.9911

6105 Transit Rd.
E. Amherst, NY 14051
P: 716.348.3435
F: 716.204.8229

300 Linwood Ave.
Buffalo, NY 14209
P: 716.961.9400
F: 716.961.9402

6400 Edgewood Dr.
Niagara Falls, NY 14304
P: 716.898.4803
F: 716.898.3928

462 Grider St.
Buffalo, NY 14215
Nephrology
P: 716.898.4803
F: 716.898.3928
Behavioral Med:
P: 716.898.5671

UBMD Internal Medicine Patient Agreement

Thank you for choosing UBMD Internal Medicine as your healthcare provider. Our practice is committed to providing you with the highest quality care, service and access. In order to help accomplish these goals, below is some introductory information and our financial policy.

General Information
Billing Office: 716.816.7200
Hours: Monday - Friday 7:30 am – 4:30 pm
Patient Website: ubmdim.com

If you wish to contact a physician regarding a medical matter, please call the appropriate office above or use the Patient Portal (see information on page 2). **DO NOT contact physicians via University or buffalo.edu email**, as they are not HIPAA-compliant and do not offer protection for health information. A medical provider is on call seven (7) days a week to take urgent calls outside normal business hours. Your call will be returned within one (1) hour. **For emergencies, call 911.**

Our phone message is updated as needed to report any weather-related closings.

Appointments
Please arrive 15 minutes prior to your appointment time to register. For your benefit and the benefit of all our patients, we try to stay on schedule (though emergencies sometimes occur) and aim for patients to be in the exam room at their appointment time. You will receive an automated pre-appointment reminder call two (2) to five (5) business days before your appointment. It is important for you to notify our office if your phone number has changed. Please specify if you prefer your home or mobile number as your primary contact.

Prescription Refills.
For routine refills, please contact your pharmacy and have them send a prescription refill request electronically. Refills can be requested through our Patient Portal for those who are currently enrolled. Please allow five (5) business days to have all medications refilled. For refill requests needed in less than five (5) business days, contact the office.

Form Completion Fee
There will be a $10 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of request. Please allow seven (7) business days for us to complete any forms.

Test Results
Please allow seven (7) business days for laboratory results or other diagnostic test results unless instructed by your physician. Your physician will review all test results and contact you if follow up is needed. Routine lab results may be relayed by postal mail, patient portal or telephone.

Address and/or Phone Number Change
Please advise our practice anytime there is a change in your address, phone number, or other contact information. Our staff is required to verify all demographic and insurance information at every visit.

Financial Policy
Your clear understanding of our Patient Financial Policy (available on our Patient Resources web page, or by request at the office) is important to us. Please ask if you have any questions about our fees, policies, or your responsibilities.

Insurance Verification and Copayments
Patients are expected to present valid photo identification and their insurance card at each visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing supervisor. Failure to pay your copay at the time of service will result in an additional $10 fee. We accept cash, check, credit card or flexible spending card. No post-dated checks are accepted. A $35 returned check fee is added to any insufficient funds amount owed by the patient. The patient may be placed on a cash-only basis following any returned check.

Insurance Claims
The practice will bill the patient's primary insurance company. In order to properly bill the insurance company, the practice requires that the patient disclose all insurance information including primary and secondary insurance, as well as any insurance changes. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although the practice may estimate the amount the insurance company may pay, it is the insurance company that makes the final determination of the patient's eligibility and/or benefits. The patient is responsible and agrees to pay for any non-covered services provided. If the insurance company is not contracted with the practice, the patient agrees to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance.

Participating Insurances
The practice accepts most insurance plans including but not limited to: Blue Cross/Blue Shield, Empire, Fidelis, Independent Health, Univera, United Healthcare, Wellcare, and Medicare. Participation in insurance plans may change. It is your responsibility to verify if UBMD Internal Medicine participates in your plan. If your physician does not participate with your insurance, you have the right to request an estimate of cost.

High Deductible Plans (Health Savings Accounts or Health Reimbursement Accounts)
If your insurance is a High Deductible Plan, you will be required to pay a $75 deposit prior to your visit. If the total cost of services rendered is more than $75 you will be billed for the remaining amount. If the cost of your visit is less than $75 we will send you a refund for the difference. Refunds will be issued within 60 days if the overall patient account has a credit balance.

Referrals and Authorizations
It is the patient's or guarantor's responsibility to be aware of the details of his/her insurance coverage, including any requirements for referrals and/or authorizations. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage. If your insurance company requires a referral and/or authorization (for specialist visits/testing), you are responsible for obtaining it. Failure to obtain the referral or preauthorization may result in a lower payment or no payment from the insurance company and the balance will be the patient's responsibility. To verify if we have received the appropriate referral or authorization, please contact our office.

Patient Portal
The UBMD FollowMyHealth Patient Portal provides all participating UBMD patients the ability to communicate securely and manage their own healthcare with UBMD providers, 24 hours, seven (7) days a week. All messages received through the Patient Portal will be answered within one (1) business day. The ability to view portions of your medical records, verify or request appointments, request prescriptions, update demographic information, receive reminders and ask a question of your provider are some functions of the portal. All patients are encouraged to notify our UBMD Internal Medicine staff by phone/at your next visit to request an invitation to create an account on FollowMyHealth to become participants of the UBMD Patient Portal.

Self-pay Accounts
Self-pay accounts are for patients without insurance coverage or patients without an insurance card on file with UBMD. This includes patients who have applied for Medicaid but who do not yet have a valid Medicaid number. The practice does not accept attorney letters or contingency payments. It is always the patient's responsibility to know if the practice participates with their insurance plan. If there is a discrepancy with the insurance information on file with the practice, the patient is considered self-pay unless otherwise proven. Self-pay patients are expected to make a down payment at the time of service *($115 for new patients* and *$75 for established patients*). If the down payment does not cover all treatment charges, the patient is billed for the remaining balance. Payment plans are available if needed. Please contact the billing office (716.816.7200) to discuss a mutually agreeable payment plan. It is not the intention of the practice to cause hardship to patients, only to provide them with the best care possible and the least amount of stress. Failure to make the deposit at the time of service, will result in an additional $10 fee.

Workers' Compensation and Automobile Accidents (No Fault)
In the case of a workers' compensation injury or automobile accident, the patient must have the claim number, phone number, contact person, and name and address of the insurance carrier with them at the office visit. If this information is not provided, the patient will be asked to either reschedule the appointment or pay for the visit at the time of service.

No Show/Cancellation Fee
The practice requires 24-hour notice of appointment cancellation. If this procedure is not followed, a $35 fee is assessed to the patient.

Medical Record Copies
Patients requesting copies of medical records are charged $.75 per page. A charge of $15 applies for the retrieval of records in off-site storage, including those medical records transferred from another practice.

Minors
The parent or guardian who holds the insurance for the child is considered the guarantor for the child and is responsible for full payment regardless of personal circumstances. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy
A billing statement is sent to the patient/guarantor upon rendering of services. Statements are mailed every twenty-eight (28) days thereafter. If a patient's account is sixty (60) days past due, the patient is sent a Final Collection letter requesting payment within fifteen (15) days. Telephone calls may be made to the patient prior to sending an account to a collection agency in a final attempt to collect the outstanding balance. If no payment is received, the account is sent to a collection agency. Statements returned with an invalid address, will be sent to the collection agency. Any account sent to a collection agency will include collection, attorney and court fees and may be reported to credit bureaus.

Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made, pursuant to this agreement, your account may be turned over to a collection agency.

Regardless of any personal arrangements that a patient might have with outside individuals or groups, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other individual.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

UBMD Internal Medicine

Assignment of Benefits, Financial Responsibility, Release of Information And Receipt of Notice of Privacy Practices

- **Assignment of Benefits**
  I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to UBMD Internal Medicine for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.
  Please initial x_____

- **Financial Responsibility**
  I have requested medical services from UBMD Internal Medicine on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred during the course of treatment. I also acknowledge that I have read the financial policy of the practice, agree to be bound by its terms and understand that such terms may be amended from time-to-time by the practice.
  Please initial x_____

- **Release of Information**
  I authorize the release of necessary medical information to UBMD Internal Medicine for the purpose of processing this or any related claim. I also authorize UBMD Internal Medicine to release requested documentation of this claim or any related claim to myself and/or other health care providers involved in the treatment of my condition.
  Please initial x_____

- **Teaching Facility**
  I acknowledge that UBMD Internal Medicine is affiliated with the University at Buffalo School of Medicine and Biomedical Sciences and as such students may become involved in my care. If you are concerned about the involvement of medical students, please speak to the physician responsible for your care.
  Please initial x_____

- **Phone Notifications**
  I authorize UBMD Internal Medicine to remind me of my appointments and other useful information using automatic, prerecorded or artificial voice calls to me on the phone number I listed; even if it is a cellular phone number
  Please initial x_____

- **Notice of Privacy Practices**
  We are required to provide you a copy of our Notice of Privacy Practices which describes how medical information about you may be used and disclosed and how you can get access to this information. Any restrictions concerning the use of your personal medical information must be made in writing. By signing below, I acknowledge that I received a copy of UBMD Internal Medicine's Notice of Privacy Practices.
  Please initial x_____

Documentation of Good Faith Efforts – For UBMD Internal Medicine use only

A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of UBMD Internal Medicine's Notice of Privacy Practices. However, such acknowledgment was not obtained because:

_____ Patient refused to sign
_____ Due to an emergency, it was not possible to obtain an acknowledgement
_____ Unable to communicate with patient
_____ Other (please provide specific details)

_____

_____

_____ _____

Employee Signature Date

_____ _____

Patient Name (print) Patient Date of Birth

_____ _____

Patient Signature or Responsible Party if a Minor Date