UB|MD
INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

Primary & Specialty
1001 Main St.
Buffalo, NY, 14221
P: 716.961.9900
F: 716.961.9911

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

Nephrology
462 Grider St.
Buffalo, NY, 14215
P: 716.898.4803
F: 716.898.3298

Behavioral Medicine
462 Grider St.
Buffalo, NY, 14215
P: 716.898.5671
F: 716.898.3040

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. To help accomplish these goals, we would like to provide you with the following information regarding our practice, including our financial policy.

General Information
Billing Office: 716.816.7200
Office Hours: Monday - Friday 8:00am – 5:00pm
Website: ubmdim.com

If you wish to contact a provider regarding a medical matter, please call the appropriate office above or use the Patient Portal (see page 2). **DO NOT contact physicians via University or buffalo.edu email**, as they are not HIPAA compliant and do not protect patient 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 promptly. **For emergencies, call 911.**

Our phone message is updated as needed to report any weather-related closings. Closures are also reported to local media (WIVB-TV Channel 4, WGR2-TV Channel 2, and WKBW-TV Channel 7) under UBMD Internal Medicine or by location address.

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. If you are more than 10-15 minutes late, your appointment **may** need to be rescheduled. You will receive an automated pre-appointment reminder call two (2) to five (5) business days before your appointment.

Prescription Refills
For routine refills, please contact your pharmacy to have them send an electronic refill request to our office. 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 any refill requests needed in less than five (5) days, please contact our office.

Form Completion
There will be a $15 service charge for completion of forms not associated with an office visit. The fee is due at the time of request, please allow seven (7) to ten (10) business days 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 needed.

Address, Phone or Insurance Changes
It is important that our practice has your correct address and phone number on file. Please advise the practice anytime there is a change to 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 Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, policies, or your responsibilities.

Insurance Verification and Co-pays
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 time of check-in unless previous arrangements have been made with our billing department. Failure to pay your copay at the time of service will result in an additional $20 fee. The practice accepts cash, check or credit card. **No** post-dated checks are accepted. A $35 fee is added for any returned check owed by the patient.

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 active insurance plans, 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 benefits. The patient is responsible 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's your responsibility to verify if UBMD 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 Heath Reimbursement Accounts)
If your insurance is a High Deductible Plan you will be required to pay a $125 deposit for New Patients and $75 for a Follow Up prior to your visit. If the total cost of services rendered is more than your deposit, then you will be billed for the remaining amount. If the cost of your visit is less than the deposit, then we will send you a refund or account credit for the difference.

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 insurances. **If your insurance company requires a referral and/or authorization for visits, you are responsible for obtaining it.** Failure to obtain the referral may result in a lower payment or no payment from the insurance company and the balance will be the patient's responsibility.

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

Self-pay Accounts
Self-pay accounts are for patients without insurance coverage or patients without an insurance card on file with UBMD. 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 (*$125 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 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.

Workers' Compensation and Automobile Accidents (No Fault)
In the case of a workers' compensation injury or automobile accident, the patient must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to the 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
The practice requires 48-hour notice of appointment cancellation. If this procedure is not followed, a $50 fee for new patients and/or $25 fee for existing patients 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(s) or guardian(s) who holds the insurance for the child is considered the guarantor and is responsible for full payment and will receive the billing statement. A signed release to treat will be required for unaccompanied minors.

Outstanding Balance Policy
A billing statement is sent to the patient (or guarantor of the account) 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. If no payment is received, the account is sent to a collection agency. Telephone calls may be made to the patient prior to sending an account to collection in a final attempt to collect the outstanding balance. Statements returned with a bad address, where a valid address cannot be located, will be sent to the collection agency. If no resolution can be made, the account will be sent to a collection agency, referred to an attorney, and will be subject to possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of the office, 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 personal party.

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 for 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_____

- **Notice of Privacy Practices**
  We are required to provide you with a copy of our Notice of Privacy Practices upon request, 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_____

- **Cell 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.
  Please initial x_____

UBMD Internal Medicine use only

Documentation of Good Faith Efforts

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 acknowledgement 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