

## **NOTICE OF PRIVACY PRACTICES**

**RICHARD JOHNSON, M.D.**  
500. S. UNIVERSITY, SUITE 318  
LITTLE ROCK, AR. 72205

Telephone: (501) 664-8000

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND IS DISCLOSED. PLEASE REVIEW IT CAREFULLY.**

This notice takes effect on December 1, 2002 and remains in effect until we replace it.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We created a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

The law requires us to keep all of your medical information private and to give you this notice describing our legal duties, privacy practices, and your right regarding your medical information. We have the right to change our privacy practices and the terms of this notice at any time, provided that law permits the changes.

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. We may use and disclose your medical information for payment purposes by giving your insurance company the information needed to pay your claims.

In addition to using and disclosing your medical information for treatment and payment, we may disclose information for the purpose of notifying a family member, your personal representative or the person responsible for your care. If you are present, we will get your permission if possible, or give you the opportunity to refuse permission. In the case of an emergency, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up prescriptions, medicine, and medical information about you.

We may disclose information in response to a court order, subpoena, discovery request or other lawful process. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials.

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim or abuse, neglect, or domestic violence or the possible victim of other crimes.

You have the right to look at or get copies of your medical information. You must make the request in writing. You may do this by sending a letter to the contact person at the end of this notice or requesting a form from our receptionist.

If you request copies, we will charge you \$3.50 for each page, and postage if you want the copies mailed to you.

You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

You have the right to request that we communicate with you about your medical information by different means or to different locations. Your request must be made in writing to the contact person listed at the end of this notice.

You have the right to request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to your office record. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

## Patient Rights and Responsibilities

You should be as comfortable as possible and know that **YOU** are our number one concern during your visit to our office. The following statement of your rights and responsibilities is presented as the policy of Richard Johnson, M.D., but does not presume to be a complete representation of all mutual rights and responsibilities.

### YOU HAVE THE RIGHT:

- ❖ To impartial access to the medical resources of Richard Johnson without regard to race, color, national origin, age, handicapping or disabling condition, spiritual or ethical beliefs or source of payment.
- ❖ To receive considerate, respectful care, which recognizes your personal dignity at all times and under all circumstances.
- ❖ To participate in decisions involving your care. Except in an emergency situation, you shall not be subjected to any procedure without your voluntary, competent, and understanding consent or the consent of your legally authorized representative.
- ❖ To refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal.
- ❖ To instructional and educational information about our medical treatment in a language and terms that you understand.
- ❖ To the confidential treatment of and access to your medical record.

### YOU HAVE THE RESPONSIBILITY:

- ❖ To give Dr. Johnson and his staff complete and accurate information about your condition and care, including accurate billing information
- ❖ To follow instructions of Dr. Johnson and his staff and to keep appointments relative to your care.
- ❖ To make it known whether you clearly understand planned actions and treatment and what is expected of you.
- ❖ To report unexpected changes in your condition to Dr. Johnson or his staff.
- ❖ To accept the financial obligations associated with your care.
- ❖ To advise Dr. Johnson or his staff of any dissatisfaction you may have regarding your care.
- ❖ To be considerate of other patients and staff members caring for you.

## **FINANCIAL POLICY**

This is an agreement between Dr. Richard Johnson, as creditor, and the Patient or responsible party, as debtor.

In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to the medical practice of Richard Johnson, M.D.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge (12% apr on all balances over 30 days), and any payments or credits applied to your account during the month.

**Payments:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days from the statement date.

**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Required Payments:** Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

**Payment options if you have no insurance:** You may choose to pay by cash, check, money order, Visa or MasterCard at the time services are rendered.

**Payment options if you have insurance:** You may choose to pay your deductible and/or co-pay by cash, check, money order, Visa or MasterCard at the time services are rendered.

**Insurance:** If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain proper referral/preauthorization may result in lower payment from your insurance company.

Insurance is a contract between you and the insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

**Finance Charge:** A finance charge will be imposed on each item of your account, which has not been paid within thirty (30) days of the first statement date. The **FINANCE CHARGE** will be computed at the rate of one (1) percent per month or an **ANNUAL PERCENTAGE RATE** of twelve (12) percent. The finance charge on your account is computed by applying the

periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collections agency, you agree to pay all of the collections costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. In case of a suit, you agree the venue shall be in Pulaski County, Arkansas.

**Returned checks:** There is a fee of \$25.00 for any checks returned by the bank.

**Transferring of Records:** You will need to request in writing, and pay a reasonable copying fee, if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

**Waiver of Confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit

reporting agency, that fact that you received treatment at our office may become a matter of public record.

**Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. If written cancellation is received, it becomes effective with any subsequent charges.

Patient's Name: \_\_\_\_\_

Responsible Party (if not patient): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature: \_\_\_\_\_ Date: \_\_\_\_\_