RVA ALLERGY

Welcome! Thank you for choosing Dr. von Elten and RVA Allergy. We strive to offer quality care to all of our patients and look forward to participating in your care. For your convenience we have attached our forms and policies. You must review each form prior to signing the acknowledgements for the Financial and Release of Billing Policy and Notice of Privacy Practices (collectively, the "Welcome Packet"). Please review the Welcome Packet carefully, including the provisions that you are signing on behalf of the Responsible Parties (as defined in the Financial and Release of Billing Policy). If you have any questions, please do not hesitate to ask. For more information, please review our website at rvaallergy.com.

This Welcome Packet includes:

- RVAA 2024 Financial and Release of Billing Policy
- RVAA 2024 Notice of Privacy Practices

I, _____ (patient/patient legal representative), hereby acknowledge that I have received a copy of the Forms listed above, including RVA Allergy's Notice of Privacy Practices (Notice Regarding Privacy of Personal Health Information) and RVA Allergy's Financial and Release of Billing Policy. I have been provided a copy, read, understand, and will comply with the terms of RVA Allergy's Financial Policy.

Patient's Name: _____ Date of Birth: _____

Responsible Party: _____

SSN of Responsible Party: _____

SIGNATURE: _____ Date: _____

Below is a list of persons who are authorized to view any medical information in this medical chart:

_____ _____

_____ _____

RVA Allergy, LLC | Kelley von Elten, MD
7229 Forest Ave | Suite 104B | Richmond, VA 23226
Phone: (804) 285-5000 | Fax: (833) 979-0929

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RVAA 2024 FINANCIAL AND RELEASE OF BILLING POLICY

We are committed to providing you with quality and affordable healthcare. Please read the following carefully because it describes your financial obligations for treatment rendered. Feel free to ask us any questions. A copy will be provided to you upon request.

PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN REQUESTED AND APPROVED IN WRITING IN ADVANCE. YOU ARE EXPECTED TO PAY ACCORDING TO THE ARRANGEMENT.

PAYMENT RESPONSIBILITY: The Responsible Parties (as defined hereinafter) agree to this Financial and Release of Billing Policy, including this Payment Responsibility section. **YOU, YOUR LEGAL REPRESENTATIVE (IF APPLICABLE), AND THE PLAN SUBSCRIBER (I.E., THE PERSON SUBSCRIBING TO OR CARRYING THE INSURANCE PLAN FOR THE PATIENT APPOINTMENT) (COLLECTIVELY, "RESPONSIBLE PARTIES") ARE ULTIMATELY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED. YOU REPRESENT AND WARRANT THAT THE INFORMATION PROVIDED IN THE WELCOME PACKET IS ACCURATE AND THAT YOU POSSESS THE LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON BEHALF OF THE RESPONSIBLE PARTIES.** Payment is expected at time of service for all charges owed for the current visit as well as any prior balance. For those insurance plans with real time adjudication, payment will be collected at check out for charges incurred that day. For insurance plans that do not provide immediate patient responsible information, settlement of your balance may be accomplished via card-on-file (preferred) or you may pay a deposit on date of service.

INSURANCE: We participate with many insurance plans. Your insurance is a contract between you and your insurance company. We are not privy to the terms of your contract. We will not estimate what your insurance company may pay—the insurance company will determine your eligibility and provide the amount of your financial responsibility under your contract. You need to contact your insurance company to verify participation, benefits, and copay. If your insurance company states you are ineligible for benefits, you will be considered self-pay. You may be asked to sign a form estimating charges for services that may be deemed non-covered by your insurance company.

WE DO NOT PARTICIPATE WITH MEDICARE, MEDICAID, NOR TRICARE. YOU HEREBY REPRESENT AND WARRANT THAT NEITHER YOU NOR ANY PATIENT HERE ON WHOSE BEHALF YOU SIGN IS A MEDICARE, MEDICAID, OR TRICARE BENEFICIARY. YOU AGREE TO TELL US IF YOU OR THE PATIENT YOU REPRESENT IS A MEDICARE, MEDICAID, OR TRICARE BENEFICIARY PRIOR TO RECEIVING ANY SERVICES. FURTHER, YOU AGREE TO PROVIDE INFORMATION FOR ALL PAYORS FOR YOURSELF AND ANY PATIENT ON WHOSE BEHALF YOU SIGN PRIOR TO RECEIVING SERVICES.

CO-PAYMENTS AND DEDUCTIBLE: All co-payments must be paid at the time of service. Each Responsible Party is responsible for your deductible and co-insurance according to your insurance plan.

OUTSTANDING BALANCE: You or a Responsible Party must pay any outstanding balance prior to scheduling any appointment for you or any member of your family.

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PAYMENT PLANS: In limited circumstances, we may offer a payment plan for outstanding balances. For any payment plan the minimum monthly payment will be the greater of: (i) $100; or (ii) 10% of the outstanding balance for the visit. Please see our business office for details.

FAMILIES: Families with two or more family members each scheduled on the same day will be required to provide a deposit of $250.00.

SELF-PAY (NO INSURANCE): You will be required to pay in full at the time of service. New patients are required to pay a minimum of $250.00, which may be increased if testing will be rendered. Upon request, we will have a member of the business office discuss the cost of additional charges before we perform any testing.

CLAIMS SUBMISSION: We will submit claims to your insurance. We may, but are not required to, assist you in obtaining payment from your insurance company. Your insurance company may need you to supply certain information directly, and you must comply as directed. The balance of your claim is the responsibility of each Responsible Party regardless of payment by your insurance company.

REFERRALS: Some insurance plans require a referral authorization from your primary care physician or pediatrician. If we have not received a referral prior to your arrival at our office, you may be rescheduled.

PROOF OF INSURANCE/ COVERAGE CHANGES: All patients must complete our Patient Information form before any visit. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with this information in a timely manner, you will be responsible for the balance on your account. Some insurance companies will deny charges if filed later than 90 days after the date of service.

METHODS OF PAYMENT: We accept payment by Cash, Check, Debit/Credit Cards, HSA cards, Cashier or Certified Check.

PATIENT STATEMENTS: If you have an unpaid balance, you will receive a statement monthly by mail. Statements are also available on-line through the Patient Portal. The statement is due and payable when the statement is issued, and past due if not paid upon receipt. Balances over 90 days will be turned over to our internal collection department and/or may be submitted to an outside collection agency with possible dismissal from the practice. Balances may also be submitted to our attorney for collection.

COLLECTION FEES: Accounts submitted to the collection agency or attorney are not eligible for payment plans. All collection costs, including our attorney's fees, may be charged back to the account. Patients referred to the collection agency will be required to have prior approval before your visit is scheduled. If we, or our attorney, files a lawsuit to collect an outstanding balance, you and each Responsible Party agree to pay our reasonable attorney's fees if we prevail in our lawsuit. Accounts 60 days past due will be subject to interest at a rate of one percent per month, or the maximum rate allowed by law, whichever is greater.

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RETURNED CHECKS: Your account will be charged a $35.00 service fee for checks not honored by your bank. The check and service fee must be paid in full before your next visit.

LATE ARRIVALS, CANCELATIONS, AND NO-SHOWS: Patients are expected to inform us if they are unable to make scheduled appointments, including if they will be late. Patients who arrive more than 15 minutes after an appointment's scheduled start time will be considered "Late." Patients who arrive late may be asked to reschedule or discharged from the practice. Patients who do not give at least one business day's notice that they will be unable to make a scheduled appointment, and patients who do not show up for a scheduled appointment will be considered a "No-Show" in each instance. No-Shows deprive other patients of an opportunity to receive timely care by taking an appointment slot that could go to another patient. Accordingly, any patient who is a No-Show for two (2) or more appointments will be charged a no-show fee of 100% of the appointment fee for each No-Show appointment. No-Show patients may also be discharged from the practice.

FORM FEES: There is a $35.00 fee to fill out forms up to 3 pages in length if requested or completed outside of a visit. Forms longer than 3 pages will be subject to additional cost. There is a $50.00 fee for letters.

PORTAL COMMUNCIATIONS: If it has been more than seven days since your last visit and you initiate a portal message that does not result in an appointment, your insurance may be billed for those services.

RELEASE OF BILLING INFORMATION: I, the above-signed, consent to the use of my Protected Health Information for treatment and payment for treatment. I allow RVA Allergy to bill my insurance and assign, except as otherwise provided by law or other agreement, directly to RVA Allergy all medical benefit, if any, otherwise payable to me for services and supplies rendered. I understand that RVA Allergy will share patient protected health information according to the federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices. I hereby authorize RVA Allergy to release all information necessary to secure payment of benefits to my insurance company. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I acknowledge and understand that all charges remaining after insurance reimbursement will be billed.

This Financial and Release of Billing Policy is effective as of April 1, 2024.

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RVAA 2024 NOTICE OF PRIVACY PRACTICES
(NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal Regulations developed under the Health Insurance Portability and Accountability Act, as amended, (HIPAA) require that we provide you with this notice.

Uses and Disclosures

Treatment. We may use your protected health information, as defined under HIPAA (PHI) or disclose your PHI to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures may be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. We may use your PHI to seek payment for health care services that we provide to you, including from your health plan, from other sources of coverage such as an automobile insurer, workers compensation carrier or from credit card companies that you may use to pay for services, or consumer reporting agencies relating to collection of premiums or reimbursement. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health care operations. We may use your PHI as necessary to support the day-to-day activities and management. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement and Government Functions. We may disclose your PHI to the police or other law enforcement officials as required by law or in compliance with a court order. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

Coroners, Medical Examiners, Funeral Directors, Organ Donation. We may disclose your PHI to a coroner or medical examiner as authorized by law. Your health information may be disclosed to coroners and/or medical examiners for purposes of identification, determining cause of death, or other duties as required by law. We may also disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Public health reporting. We may disclose your PHI to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department, or to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed herein requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. We may use your PHI to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Research. Your protected health information will not be disclosed for research, unless written authorization is obtained.

Marketing. Your protected health information will not be used for marketing, unless written authorization is obtained. For example, we will not accept any payments from other organizations or individuals in exchange for making communications to you about treatments, therapies, health care providers, settings of care, case management, care coordination, products or services unless you have given us your authorization to do so or the communication is permitted by law. We may provide refill reminders or communicate with you about a drug or biologic that is currently prescribed to you so long as any payment we receive for making the communication is reasonably related to our cost of making the communication. In addition, we may market to you in a face-to-face encounter and give you promotional gifts of nominal value without obtaining your written authorization. We will not use your information for any type of fund-raising endeavor.

Prohibited Uses and Disclosures for Protected Health Information

Except as otherwise provided, we will not use your PHI as follows without your written authorization:

- We will not use your PHI, including your genetic information, for underwriting, determination of eligibility and benefits, computation of premium or contribution amounts, application of any pre-existing condition, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.
- We will not make any disclosure of Protected Health Information that is a sale of Protected Health Information without your written authorization. The sale of protected health information by the health care provider or its business associates for a fee. A cost-based fee for preparation and transmittal purposes to an authorized provider or insurance company is permissible.

RVA ALLERGY

Individual Rights and Our Duties

You have certain rights under the federal privacy standards. These include:

- The right to request restriction on the use and disclosure of your protected health information.
- The right to Receive communications by alternative means or at alternative Locations. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to appoint someone your medical power of attorney or legal guardian, that person can exercise your rights and make choices about your health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Our Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our privacy practices. We are required to notify you of a breach, which results in the compromise of security or privacy of your protected health information. We are required to abide to the privacy policies and practices that are outlined in this notice (or other notice in effect at the time of the use or disclosure).

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records, please obtain a record request form from us and submit the completed form to us as directed on the form. If you request copies, we may charge you a reasonable copy fee.

Concerns. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

RVA Allergy
Attn: Privacy Officer for HIPAA
7229 Forest Ave, Ste 104B
Richmond, VA 23226

RVA ALLERGY

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

For further information please visit the HHS website available at (as of March 31, 2024): **https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html**

Patient's Name: _____ Date of Birth: _____

Responsible Party: _____

SIGNATURE: _____ Date: _____

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