Adam W. Bagley, MD, FACR
Diplomate of American Board of Rheumatology
Diplomate of American Board of Internal Medicine
Pinki Patel, PA Carol Hill, ARNP
2100 Kingsley Ave. Orange Park, FL 32073, Phone (904)276-0001 Fax (904) 276-5333

CONSENT FOR TREATMENT

I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me because of treatments or examination. I have the right to refuse tests or treatment and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this. This consent continues even after a specific diagnosis has been made and treatment recommended. This consent will remain until cancelled in writing.

RELEASE OF BILLING INFORMATION FOR PAYMENT

I give my permission for Arthritis and Osteoporosis Treatment Center (“AOTC”) to bill my health insurance company for services provided to the patient’s name listed on this form. I agree and acknowledge that my signature on this document authorizes AOTC to submit claims for service rendered without obtaining my signature on each claim to be submitted for patient name listed on this form and that I will be bound by this signature as though the undersigned had personally signed the particular claim. During the course of treatment for the patient’s name listed on this form at AOTC, I understand that there may be occasions for charges of non-face to face visits, treatment recommendations, and/or review of records. I give my permission for AOTC to bill my insurance company for these services and any amount deemed patient responsibility by the insurance company will be billed to me accordingly. I further authorize and request that insurance payments be made directly to Arthritis & Osteoporosis Treatment Center should they elect to receive such payment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To maintain continuity of care, I give permission to AOTC to release my medical records to any specialists, hospital or medical facilities associated with my care plan. I understand that Pandya Medical Center abides by HIPAA regulations and that only the records pertinent to the visit and my health will be released.

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CHANGES TO THIS NOTICE

AOTC reserves the right to change this notice. AOTC reserves the right to revise or change the notice effective for medical information on file as well as any information received in the future. AOTC will post a copy of the current notice in the practice lobby. The notice will contain on the first page in the bottom left-hand corner the effective date. In addition, each time you register for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact the Privacy Official at (904)276-0001. You will not be penalized for the filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to AOTC will be made only with your written permission. If you choose to provide AOTC permission to use or disclose medical information about you, you may revoke this permission in writing at any time. If you revoke your permission AOTC will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that AOTC is unable to take back any disclosures already made with your permission and that AOTC is required to retain our records of the care that we provided to you.

By signing below I acknowledge receipt of the afore outlined notices.

Patient Name (Print)

Patient Signature

Date

Updated December 2024

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Permission To Discuss Medical Care

I hereby give permission to AOTC discuss my medical case and personal information with the following individuals:

(Please list names and relationship to you)

1. _____ Relationship to Patient _____ Phone #: _____
2. _____ Relationship to Patient _____ Phone #: _____
3. _____ Relationship to Patient _____ Phone #: _____
4. _____ Relationship to Patient _____ Phone #: _____

I understand that the above-mentioned individuals may speak to AOTC concerning my medical condition. The above also has my permission to sign for any prescriptions, imaging or medical records that may need to be picked up from the office for me in the future.

I also authorize AOTC to leave a voice messages regarding my treatment, blood work results, appointments and or billing issues.

I understand that in the future if I wish to revoke my permission, I must notify AOTC in writing.

_____
Patient signature

_____
Date

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STATEMENT OF POLICIES

The following policies are outlined for mutual convenience and benefit. Please read carefully and acknowledge understanding with signature. Questions or concerns should be addressed prior to signing.

1. We strictly provide rheumatological services. **We do not provide primary care services**. Patients are expected to have or arrange for a primary care provider. Medicare enrollees are expected to have at least one annual **well** visits with primary care provider.
2. AOTC does not perform evaluation or paperwork for disability. There will be a fee of $200 for all FMLA or accommodations forms. Turnaround time for any forms is 7 days.
3. Deductible and co-pay associated with each visit are payable at the beginning of that visit **prior** to being seen. Any outstanding balance at the beginning of the visit is also fully payable at the time of your visit. A $25 billing fee will be added to any unpaid copays, co-insurance, deductibles or balance.
4. If you are not able to pay you may make special payment arrangements with our business office at the beginning of the visit **prior** to being seen.
5. As of 1/1/2025 you may be subject to a **3% convenience fee** to all credit card transactions. This does not include debit cards, HSA, or FSA cards. Check and cash are also accepted. There will be a $50 fee for a check that returns as nonsufficient funds.
6. AOTC electronic medical record payment processing will store encrypted credit and/or debit card payment information with verbal patient consent.
7. Patient is solely responsible for all referrals required by their insurance. It is also the patient's responsibly to ensure AOTC and providers are participating with their insurance. Patient will be responsible for any charges not covered by your insurance.
8. Appointment times are when a patient should be seen by a provider. Please arrive at least 15 minutes prior to your scheduled appointment time for follow up visits. For new patient visits please arrive 30 minutes prior to appointment time if paperwork has been completed and 45 minutes prior if paperwork is being completed in the office. Patients more **than 15 minutes late** for follow up appointment times will be rescheduled. New patients who **arrive late with no paperwork completed** will be rescheduled.
9. If you are not able to keep your appointment for office visits, imaging, procedures or infusions, please call during office hours to cancel and/or reschedule your appointment at least 48 hours in advance. **Failure to do so will result in a $50.00 no show fee.** This is required to be paid prior to the next visit. Recurring no shows will be grounds for dismissal from the practice.
10. Please refrain from wearing perfumes and other scents to the office to accommodate those with allergies or intolerance.
11. During follow-up visits only, patients may be seen by a nurse practitioner or a physician assistant who work directly under the treating physician with their oversight. The physician will also see the patient when requested. This helps ensure access to timely follow-up.

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12. Foul language, racism, and or hate speech will not be tolerated. Appropriate attire is required for office visits. Office staff are to be always treated with respect. Behaviors such as these are grounds for immediate dismissal from the practice.
13. Patient will be given an Advance Beneficiary Notice of Noncoverage (ABN) for known noncovered services by insurance prior to services rendered. Patients are expected to pay associated fees in full at time of non-covered service.
14. It is the patient's responsibility to notify the office immediately of any changes to insurance policy. Patient will be solely responsible for any nonpaid claims because of incorrect insurance information.

I acknowledge that I have carefully read and understand this Statement of Policies and agree to abide by them.

Patient Name (Print)

Patient Signature

Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name _____

Date of Birth: _____

Phone: _____

Address: _____

I do herby I authorize the use or disclosure of the above-named individual's health information as described below. I authorize Arthritis and Osteoporosis Treatment Center to make the disclosures on my behalf

- Consultations and Progress Notes
- Imaging Data
- Laboratory Data
- Infusion and Treatment Notes

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

As required by state and federal law, Arthritis and Osteoporosis Treatment Center may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of PHI described in this form

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Arthritis and Osteoporosis Treatment center cannot guarantee that the recipient of the information will not redisclose this information contrary to such parties.

I understand that this authorization will remain in effect for one (1) year or until I revoke in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Medical Records, Arthritis & Osteoporosis Treatment Center, 2100 Kingsley Avenue, Orange Park, Florida, 32073. I further understand that any such revocation does not apply to information already released in response to this authorization.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.

I understand that I have a right to inspect and to obtain a copy of any information disclosed.

I hereby release Arthritis & Osteoporosis Treatment Center and its employees from any and all liability that may arise from the release of information as I have directed.

I understand that I may be charged a fee of up to $1.00 per page for every page of printed records up to 50 pages, then 25 cents a page thereafter. This fee is waived for copies provided directly to a health care provider for continuing medical care. I understand that this fee is within the limits allowable by Florida law.

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I hereby authorize Arthritis & Osteoporosis Treatment Center to release health information as described above. The above records are being released to:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Name: _____

Address: _____

Phone #: _____

Fax #: _____

Name: _____

Address: _____

Phone #: _____

Fax #: _____

_____

Patient Name Printed

_____

Patient signature

_____

Date

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LAB DRAW CONVENIENCE FEE AGREEMENT

As of January 1, 2025 any commercially insured patient may request to have blood work drawn for follow up visits in the office at specified times which will be sent to an appropriate commercial laboratory for analysis. Labs for initial visits will be required to be completed at a commercial draw site related to the complexity of workup at the initial visit.

Laboratory draws performed in office are offered as a **convenience** and will be subject to a **fee of $20** payable to Arthritis and Osteoporosis Treatment Center (AOTC) at the time of service. It is understood this is **not a covered service** and will not be submitted to your insurance company. Along those lines this fee is **not reimbursable** by your insurance company. This service is offered solely as convenience and alternative to those who do not wish to visit a commercial draw station to have blood drawn. The patient will be solely responsible for any fees incurred by the lab where blood work is performed. It is the patients responsibly to notify phlebotomist of any specific laboratory location requirements. AOTC is not responsible for insurance denials related to insurance location restrictions. This fee does not apply to patients who are receiving infusion treatments and labs drawn at time of drug administration.

By signing below you agree that you have read and agree to the above policy.

Patient Name Printed

Patient signature

Date

Updated December 2024