Leo Toupin, M.D., P.A.

OFFICE POLICIES

Our office participates with many health insurance companies in the Austin area. We encourage you to be an informed consumer by understanding your coverage, how to access information from your carrier, and which ancillary providers, e.g. lab, and x-ray facilities, participate with your plan. You will be asked to present your insurance card(s) and a valid driver's license or identification card at your initial visit to our office. When there are changes, either in demographics or insurance coverage, it is your responsibility to inform the office and supply supporting documentation.

MEDICARE: If you are a Medicare beneficiary, you may be asked to sign an Advance Notice of Benefits (ABN) for services which may not be covered by Medicare, but are considered medically necessary by your physician. When this occurs, you will be informed about the potential charges which you may incur should Medicare deny payment of these services. There are some preventative services which your physician may recommend to establish a baseline, but are non-covered services by Medicare, e.g. routine physical examination, certain screening tests and inoculations. If you desire to have these services performed, these will be at your own expense and payment is required at the time of service.

MEDICAID: Our office does NOT participate in this program. Therefore, we cannot bill Medicaid for any services provided by this office. If you choose to see one of our providers, our expectations are the same as those for Self-Pay Patients.

SELF-PAY PATIENTS: Self-Pay Patients will receive a discount on physician services only. Other services provided within the office will NOT be discounted. Payments are required at the time services are received. THERE IS NO EXCEPTION TO THIS POLICY.

THIRD PARTY PAYORS: Patients who are established in our practice may encounter situations in which they may suffer injury or illness in which a third party may be liable (e.g. auto accident). As a courtesy to our patients, we may elect to treat a patient for any such circumstance if a valid third party payor can be contacted who will guarantee payment for such services. It is the patient's responsibility to pay for such services which may be later denied or deemed unnecessary by any third party.

WORKERS COMPENSATION: Dr. Toupin does not participate in the State of Texas or Federal Workers Compensation programs. It is the patient's responsibility to contact his/her employer to find appropriate medical care. All injuries deemed work-related will be directed to the patient's employer for determination of eligibility for Workers Compensation.

DEMOGRAPHICS: During registration it is mandatory that a copy of your driver's license (or legal identification card) and a currently active insurance card be provided for identification in your chart. It is also required that we obtain additional personal information including your social security number, physical addresses and phone numbers. It is imperative that you update your health insurance information with our office as soon as possible so as to avoid improper billing and unnecessary late fees. In addition, we request the allowance of a personal photograph at the time of registration to insure the accuracy of your identification.

FINANCIAL POLICY: We require that any applicable deductible, co-insurance or co- payment be paid at the time services are rendered. Payment may be made by cash, authorized check, Visa or MasterCard. There is a $30.00 fee for returned checks. THERE IS NO EXCEPTION TO THIS POLICY.

AFTER HOURS CALLS: Calls made to the office after hours will be redirected to a paging service. Messages may be left at the paging service which will be forwarded to the Doctor's office. A doctor on call can be reached for emergencies. This service is not intended for non-emergent calls such as prescription refill requests, appointment requests, and other services provided routinely during office hours. The office reserves the right to charge your insurance for phone or internet consultations.

REFERRALS: Patients with HMO insurances, including some Medicare Advantage Plans require authorizations prior to appointments. We require that these requests be made at least 2 business days prior to any scheduled appointment to a referred specialist.

HMO INSURANCES: Patients with HMO insurance plans must choose Dr. Toupin as their primary care provider prior to their appointment in our office in order to allow insurance coverage of the fees of the initial office visit. It is the responsibility of the patient to implement this designation at least one day prior to their office visit.

CANCELLATIONS: When you are unable to keep an appointment, please notify our office promptly. We will gladly try to change appointment dates and times to accommodate your schedule if you provide a 24 hour notice prior to your scheduled appointment. Our office reserves the right to charge a $50.00 no show fee for failure to provide 24 hour notice of appointment cancellations. The no show fee must be paid prior to any future appointments. As a courtesy, appointment reminder calls will be made to you through an automated calling service at least 24 hours prior to your appointment. You will have the opportunity to confirm or cancel your appointment through the use of this service. However, it is your responsibility to cancel any scheduled appointment as this reminder call cannot be guaranteed to contact you prior to your appointment.

RELEASE OF INFORMATION: There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. These situations are mandated by federal, state and/or local government. In other situations, we will ask for your authorization before using or disclosing any protected health information (PHI). If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization. Please note that we cannot release information about a spouse or family member without an authorization to do so. Your records are maintained within an electronic medical record (EMR) that is secure and compliant with the Health Insurance Portability and Accountability Act (HIPAA). If we request and obtain records from physicians who have treated you previously, appropriate documents will be scanned into our system and the hard copies will be destroyed. If hard copies of the information are required, we reserve the right to assess a fee to recoup the associated costs of handling your request as allowed by law.

REPORTS: A minimum fee of $ 20.00 will be charged for the completion of forms and medical reports. A fee of $30.00 will be charged for detailed forms such as FMLA, health insurance questionnaires, disability forms. The assessed fee must be paid before we can release the requested information.

PRESCRIPTION REFILLS: We ask that refill requests be made at least seven(7) days in advance of your needing the medication refilled. Refill requests MUST BE MADE by contacting your pharmacy. Refill requests will be faxed by your pharmacy to our office. Most pharmacies will have our fax number on file; if not, you may ask them to fax the request to 512-977-8301. This would include the transfer of any other prescribing physician to our office If your prescriptions are being submitted to a mail order pharmacy, please allow one week for the processing of your request by our office. For patients requesting a prescription which requires insurance prior authorization, we will attempt to obtain authorization within a period of two(2) weeks. If your request cannot be processed or is denied by your insurance, then it is your responsibility to self pay for the prescription or contact our office during regular office hours to request assistance in finding an alternative medication. Refills may be given to patients seen within a six month period (3 months for controlled substance medication). If your last appointment was more than six months prior to your request, our physicians MAY authorize a refill for a 30 day supply, however an office visit within 30 days is required for future refills.

NON-COVERED ITEMS: Certain office medical procedures may not be considered covered benefits by your insurance company. Such services typically include travel vaccinations, physical examinations, screening lab tests or other procedures (e.g. cosmetic). It is the patient’s responsibility to pay for such items if denied by your insurance company. All Medicare patients are required to be informed of such items at the time of service and give consent to the fact that the service may or may not be covered.

ADVANCE DIRECTIVES: For your convenience our office maintains Texas Advance Directives, Durable Power of Attorney For Healthcare and Do Not Resuscitate Forms on file. Please request these forms or discuss their relevance during your office visit.

Office Policy 08/07/2007
Revised 04-01-2008
Leo Toupin, M.D.

CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe to you.

The long-term use of such substances as opioids (NARCOTIC pain medicines) benzodiazepine tranquilizers, and barbiturate sedatives is controversial because it is not certain whether they help chronic pain patients over the long term. These medications may also have limited benefit for other health conditions for which they are prescribed. Patients who are prescribed these drugs have some risk of developing an addictive disorder developing or suffering a relapse of a prior addiction. The extent of this risk is not certain.

Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed over the long term. For this reason we require each patient receiving long-term treatment with these medications to read and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substances to treat your chronic pain.

All controlled substances must come from a physician in this office. My controlled substances will come from the physician whose signature appears below, or during his or her absence, by the covering physician unless specific authorization is obtained for an exception.

- I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any immediate member of my immediate family.
- I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform Capital Primary Care. The pharmacy I am selecting is designated in the office electronic health record.
- I will inform Capital Primary Care of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
- I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.
- I will not allow anyone else to have, use sell, or otherwise have access to these medications.
- I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.
- I will take my medication as prescribed and I will not exceed the maximum prescribed dose.
- I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.
- I will cooperate with unannounced urine or serum toxicology screens as may be requested.
- I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder.
- I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
- I understand that medications may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill. If I request an early refill secondary to lost, damaged or stolen prescriptions twice within a year I will possibly be discharged from the practice.
- I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions(s) may not be filled prior to the appropriate date.
- If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substances administration.
- I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment and dismissal from the practice.
- I will keep my scheduled appointments in order to receive medication renewals. No refills will be given at night or on weekends.
- I understand that any medical treatment is initially a trial, and that continued prescription is contingent on whether my physician believes that the medication usage benefits me.
- I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal and over dosage.
- I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accepts all of its terms.
- I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Patient Information:

Name: ____
Date of Birth:____
Social Security: ____
Street Address: ____
City/State: ____
Zip Code: ____

Recipient of Information:

Capital Primary Care
12335 Hymeadow Drive, Suite 150
Austin, Texas 78750

Fax: 512-977-8301
Office: 512-977-8300

INFORMATION TO BE DISCLOSED:

- Facesheet
- Most Recent History/Physical
- Progress Notes
- Consultations
- Operative Reports
- Emergency Room Reports
- Laboratory Reports
- Communicable Disease
- HIV/AIDS
- Radiology/Imaging Reports
- Psychiatric/Behavioral Health Notes
- Alcohol/Substance Abuse
- Entire Medical Record

REASONS FOR DISCLOSURE:

- Continuing Care
- Consultation
- Second Opinion
- Insurance
- Other

I understand that:

1. Medical information is considered Protected Health Information (PHI) under both Federal and State Privacy Laws.

2. This authorization is voluntary and that provision of health care will not be affected if I choose not to sign.
3. This authorization will remain valid as long as I am under the care of Leo Toupin M.D., P.A. This authorization will expire when care is terminated either by myself or the treating physician.
4. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA privacy regulations.
5. I may revoke this authorization at any time by written notification to Leo Toupin, M.D., PA The revocation will not affect actions taken prior to receipt of written revocation.
6. I authorize my physician and designated staff members to release information electronically, e.g. E-mail or fax.
7. I have the right to request copy of this form after I have signed it.

Release of Information
Leo Toupin, M.D., P.A.
03-24-08

SERVICES WAIVER AGREEMENT (NON-MEDICARE)

At Capital Primary Care, we strive to make healthcare costs as affordable as possible. We have and continue to provide many services at no charge to our patients, such as email messaging for routine communications, after-hours physician telephone availability, completing simple forms and absence notes. Patients should be aware that cosmetic services and most travel vaccines are never a covered benefit by health insurance companies. In addition, many health insurance companies will not cover health expenses in the setting of 3rd party liability (for example, automobile accidents). Sometimes in the course of routine medical treatment however, a typically insurance- covered benefit may be denied coverage by one's insurance. These denials could be related to exclusions on one's policy or exclusion due to limitation of frequency of testing. It is beyond our capabilities to determine if a patient's insurance will or will not provide coverage for such items and services in the course of daily business. We expect our patients to determine if such services are covered or excluded before they receive them. Occasionally a service may be denied due to billing errors on our part. We will always resubmit to insurance a billed item if you feel it may have been billed incorrectly.

Such items and services which may be non-covered include:

1. Routine Physical Examination including PAP smears.
2. Laboratory testing for pregnancy, strep throat, rapid flu test and testing or sexually transmitted diseases.
3. Office testing including Electrocardiography testing, Pulmonary Function testing, Peripheral Vascular Disease testing.
4. Office procedures such as Skin Tag removal and E-stim treatments.
5. Vaccinations including Tetanus booster Vaccine, Influenza Vaccine, Hepatitis A and B Vaccine.

We expect our patients to pay for such items which may be denied by your insurance company. In signing this agreement, you agree to pay for such services.

By signing below I acknowledge that I have received, understood, and agreed to the above agreements in their entirety.

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Print Name:_________________________________ Date:____________________