Richard A. Reid, MD • Frederick L. Trent, MD • Mark A. Crowe, MD
William M. Gill, MD • Jennifer C. Fulton, MD • J. Kelly Wachira, MD
Eddy Gutierrez, MD • Jorge L. Alvarez, MD • Angel L. Monserrate-Vazquez, MD
Jason A. Bellardini, MD • Amit K. Babbar, MD

Dear Valued Patient,

As of January 1, 2018 all payments of co-pays, deductibles, and/or coinsurance are due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies they require that we collect these fees as they are terms of both of our health care contracts with the insurance companies. We are here to assist you with any needs you may have with this.

For your convenience, we accept credit cards including Visa, MasterCard, Care Credit, Discover, and Debit Cards, Checks and Cash and can we set up payment plans if needed.

Due to the constant changes in health insurance it is your responsibility to know your health coverage. If you should have any questions regarding if a certain procedure is covered, it is to your advantage to call your insurance company and find out exactly what your contract covers. Their customer service representatives will be happy to assist you.

Due to the amount of patients waiting to be seen at RCCSMA in the event that you do not cancel your appointment if need be within 24 hours or you do not show for your scheduled appointment you will be charged a $25 fee for returning visits, $50 fee for new patients. If you do not show for your appointment or you do not cancel within 24 hours, then there are patients who have been waiting to be seen that we could have put in your place.

Thank You,

Respiratory Critical Care & Sleep Medicine Assoc. Staff

Respiratory Critical Care and Sleep Medicine Associates

Confidential Patient Information Form - Form must be filled out completely to ensure correct claim processing. Please provide your insurance card(s) and a picture ID upon completion of this form.

Social Security_____**Patient**_____

Date of Birth_____**Address**_____

Home Tel#: _____**Work Tel#:** _____**Patient Cell #** _____

Patient E-Mail_____ **Marital Status** _____ **Employment Status** _____

How did you hear about our office? _____

Referring Physician _____**Primary Care Physician** _____

Emergency Contact _____ **Relationship**_____ **Phone #** _____

Spouse's name or other responsible party: _____ Phone # _____

Pharmacy Name, Phone #, Fax # and address_____

Primary Insurance: _____**Subscriber (Insured) Name** _____

I understand that I am directly and primarily responsible to Respiratory Critical Care and Sleep Medicine Associates (RCCSMA) for its customary fee for the services rendered to me by RCCSMA. I realize that if my insurance company fails to pay or if there is any delay in paying RCCSMA it is my responsibility to pay my doctor's bill directly. I further understand and agree if I fail to make timely payments to RCCSMA that I will be responsible for any and all reasonable cost of collection including filing fees as well as any reasonable attorney's fee(s). I understand that secondary filing is a courtesy, and if there is no payment or response from insurance company, I am responsible for the balance.

For the services rendered by RCCSMA, I authorize the release of any medical or other information necessary to process claims to my insurance carrier. This may include the diagnosis and records in the course of my examination or treatment. I also request payment of government benefits to the party who accepts assignment (RCCSMA). I authorize payment of medical benefits to RCCSMA. I agree to hold RCCSMA harmless from any and all costs, liability and damages of and nature whatsoever including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent.

I understand the office may employ an Advanced Registered Nurse Practitioner ("ARNP") or Physician Assistant ("PA"), and if I am scheduled with them, I am willing to see them instead of the doctor. I hereby consent to and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment. I consent to electronic access to my medication history.
I acknowledge that I have read this authorization and fully understand its contents.

Patient Name: _____
(Print)

DOB: _____

Patient Signature: _____

RCSM
RESPIRATORY CARE + SLEEP MEDICINE

Name: _____ **DOB** _____

Reason for Visit _____

I. **HEALTH HISTORY** (Please "circle" all that apply):

Anxiety	Depression	Kidney Disease	Rheumatoid Arthritis
Asthma	Diabetes	Liver Disease	Seasonal Allergies
Blood Clot	Emphysema	Migraine Headaches	Sinusitis
Bronchitis	Gout	Neurological illness Type:	Sleep Apnea
Cancer Type:_____	Heart Disease	Osteoarthritis	Thyroid Disease
Chronic Pain	Hepatitis Type A B C	Pleurisy	Tuberculosis
Colitis	High Blood Pressure	Pneumonia	Ulcers
Congestive Heart Failure (CHF	Insomnia	Reflux (GERD)	Other: _____
COPD	Interstitial lung disease/ Fibrosis	Restless Legs	

List all previous hospitalizations/previous surgeries:

1) _____ YEAR _____
2) _____ YEAR _____
3) _____ YEAR _____
4) _____ YEAR _____
5) _____ YEAR _____

If you are allergic to any medications please list them here for our records:

_____ _____
_____ _____
_____ _____

Please answer the following:

YES	NO	
___	___	Previous chest X-Ray? If yes, date _____ where? _____
___	___	Tuberculosis skin test? If yes, date _____ result _____
___	___	Asbestos exposure

Name: _____ **DOB** _____

Medications: (List your current medications) please attach separate paper if necessary

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SYMPTOMS: (Please circle all that apply)

General
Chills
Daytime Sleepiness
Fatigue
Fever
Frequent Illnesses
Weight Gain
Weight Loss

Skin
Hair Loss
Urticaria (Hives)

HEENT
Allergies
Bloody Nose
Blurred vision
Congestion
Dental Problems
Ears/Nose/Throat Pain
Eye Pain
Hearing Problems
Hoarseness
Light Sensitivity
Post Nasal Drip
Runny Nose
Snoring

Respiratory
Cough
Coughing up blood
Shortness of Breath
Wheezing

Cardiovascular
Chest Pain
Palpitations
Shortness of Breath, when lying
Swollen Ankles
Tachycardia (fast heart rate)

Gastrointestinal
Abdominal Pain
Constipation
Diarrhea
Heartburn
Stool Changes

Male Genitourinary
Dysuria (painful urination)
Genital Lesions
Urinating blood

Musculoskeletal
Arthralgias (joint pain)
Back Pain
Myalgias (muscle pain)

Neurological
Bed Wetting
Dizziness
Falling asleep during the day
Headaches
Leg Aching
Leg Twitching
Night Terrors
Nightmare
Pins and needles
Sleep Talking
Sleep Walking
Unable to relax leg
Weakness

Psychiatric
Anxiety
Depression
Sleep Disturbances

Endocrine
Cold Intolerance
Heat Intolerance
Increased Hunger
Increased Thirst
Increased Urine

Hematology
Bleeding
Easy Bruising
HIV Exposure
Swollen lymph nodes

II. SOCIAL HISTORY

a. Previous Occupations _____

_____

b. Present Job: _____

III. FAMILY MEDICAL HISTORY

	Age	Age Died	Medical Problems
a. Mother	____	_____	_____
b. Father	____	_____	_____
c. Brother(s)	____	_____	_____
d. Sister(s)	____	_____	_____

Please answer the following:

YES NO

___ ___ Current cigarette smoker? Number packs per day _____

___ ___ Previous cigarette smoker? Number packs per day _____ when quit? _____

How many TOTAL years have you smoked? _____

___ ___ Cigar smoker/pipe smoker/chewing tobacco?

___ ___ Does your spouse smoke?

___ ___ Drink alcoholic beverages? How often? _____

FORMULARY BENEFITS DATA CONSENT

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administration of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission for RCCSMA to access my pharmacy benefits data electronically through RxHub. This consent will enable RCCSMA to

Determine the pharmacy benefits and drug co-pays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

(Printed Name) DOB

_____ _____

Patient/Guardian Signature Date

Name: _____ **DOB** _____

SLEEP DISORDERS QUESTIONNAIRE

A good night's sleep is important to your well-being. Since most people spend roughly one third of their lives asleep, it's easy to see how the quality of sleep directly affects the quality of your life. One out of three Americans has a sleep disorder, which makes sleeping or waking hours miserable. Many of these people suffer needlessly simply because they are unaware that a problem exists. Once detected, most sleep disorders can be corrected. Filling out this questionnaire and sharing your answers with your physician may be the first and most important step in getting a good night sleep.

Please mark the box if you have experienced any of the following symptoms within the past year.

- ☐ Daytime Sleepiness
- ☐ Tonsils/Adenoids removed
- ☐ Gasping for air or choking at night
- ☐ Sleep Paralysis (awake but cannot move)
- ☐ Unrefreshing sleep
- ☐ Weakness or dropping of the knees
- ☐ Difficulty awakening
- ☐ Difficulty falling asleep
- ☐ Daytime fatigue after a night's sleep
- ☐ Loud snoring described by others
- ☐ Acting out dreams
- ☐ Someone witnessed you stop breathing during sleep
- ☐ Shift work
- ☐ Compelling urge to move legs
- ☐ Thoughts prevent me from sleeping
- ☐ I feel sad and depressed
- ☐ Fallen asleep while driving
- ☐ Been told I kick at night
- ☐ Trouble concentrating in school or at work
- ☐ Wake up and can't go back to sleep

The Epworth Sleepiness Scale

Name: _____ Today's Date: _____

Your Sex (Male = M; Female = F) _____ Your DOB **&** Age (Years) _____

How likely are you to doze off or fall asleep in the following situations, as opposed to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (for example, in a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking with someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total:	_____

Neck size: _____

Respiratory Critical Care and Sleep Medicine Associates, Inc.

NOTICE OF PRIVACY PRACTICES

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

At **Respiratory Critical Care and Sleep Medicine Associates, Inc**

("RCCSMA"), we are committed to treating and using protected health information ("PHI") about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice has been updated in accordance with the HIPAA Omnibus Rule and is effective March 23, 2013. It applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit RCCSMA; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your health information.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of RCCSMA, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. RCCSMA maintains an electronic medical record ("EMR"). You have the right to access your health record in a machine readable electronic format. You have the right to request an electronic copy of your medical record be given to you or transmitted to another individual or entity. RCCSMA may charge you a reasonable, cost-based fee for the labor and supplies associated with copying or transmitting the electronic PHI.
- Amend your health record which you believe is not correct or complete. RCCSMA is not required to agree to the amendment if you ask us to amend information that is in our opinion: (i) accurate and complete; (ii) not part of the PHI kept by or for RCCSMA; (iii) not part of the PHI which you would be permitted to inspect and copy; or (iv) not created by RCCSMA, unless the individual or entity that created the information is not available to amend the information. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.
- Obtain an accounting of disclosures of your PHI. We are not required to list certain disclosures, including (i) disclosures made for treatment, payment, and health care operations purposes, (ii) disclosures made with your authorization, (iii) disclosures made to create a limited data set, and (iv) disclosures made directly to you. The first list you request within a 12-month period is free of charge, but RCCSMA may charge you for additional lists within the same 12-month period. RCCSMA will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- Communications of your health information by alternative means (e.g. e-mail) or at alternative locations (e.g. post-office box).
- Place a restriction to certain uses and disclosures of your information. In most cases RCCSMA is not required to agree to these additional restrictions, but if RCCSMA does, RCCSMA will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). RCCSMA must comply with a request to restrict the disclosure of PHI to a health plan for purposes of carrying out payment or health care operations if the PHI pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a copy of your health care information in paper or a machine readable electronic format.

Our Responsibilities

RCCSMA is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured PHI has been accessed, acquired, used or disclosed to an unauthorized person. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, such revised Notices will be made available to you.
We will not use or disclose your health information without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the RCCSMA Privacy Officer at:

Respiratory Critical Care and Sleep Medicine Associates, Inc

1325 San Marco Blvd, Reid Building, Suite 300
Jacksonville, Florida 32207
Telephone: (904) 253-6910

If you believe your privacy rights have been violated, you can file a written complaint with RCCSMA's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, RCCSMA operates an EMR. This is an electronic system that keeps health information about you. RCCSMA may also provide a subsequent healthcare provider with health information about you (e.g., copies of various reports) that should assist him or her in treating you in the future. RCCSMA may also disclose health information about you to, and obtain your health information from, electronic health information networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

RCCSMA may use a prescription hub which provides electronic access to your medication history. This will assist RCCSMA health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to provide services on our behalf and disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Name: _____ DOB _____

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in person, or by encrypted e-mail, in reference to any items that assist RCCSMA in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist RCCSMA in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany you into the exam room, it is considered implied consent that a disclosure of your PHI is acceptable.

Open treatment areas: Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, others may overhear some patient information while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our Privacy Officer.

To Avert a Serious Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual. RCCSMA Clinic may use a single compound authorization to combine conditioned and unconditioned authorizations for research (e.g. participation in research studies, creation or maintenance of a research database or repository), provided the authorization: (i) clearly differentiates between the conditioned (provision of research related treatment is conditioned on the provision of a written authorization) and unconditioned research components; and (ii) provides the individual with an opportunity to opt in to the unconditioned research activities.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties

Deceased Individuals: In the unfortunate event of your death, we are permitted to disclose your PHI to your personal representative and your family members and others who were involved in the care or payment for your care prior to your death, unless inconsistent with any prior expressed preference that you provided to us. PHI excludes any information regarding a person who has been deceased for more than 50 years.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. However, we must obtain your prior written authorization for any marketing of products and services that are funded by third parties. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. We may also disclose certain elements of your PHI, such as your name, address, phone number and dates you received treatment or services at RCCSMA, to a business associate or a foundation related to RCCSMA so that they may contact you to raise money for RCCSMA. If you do not wish to receive further fundraising communications, you should follow the instructions written on each communication that informs you how to be removed from any fundraising lists. You will not receive any fundraising communications from us after we receive your request to opt out, unless we have already prepared a communication prior to receiving notice of your election to opt out.

Sale of your PHI: RCCSMA may not "sell" your PHI (i.e., disclose such PHI in exchange for remuneration) to a third party without your written authorization that acknowledges the remuneration unless such an exchange meets a regulatory exception.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your health information if we are required by law to do so.

Acknowledgment of Receipt of Notice

I acknowledge that I have had the opportunity to review a copy of RCCSMA's Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify RCCSMA, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand RCCSMA has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.RCCSMA.com. RCCSMA will provide me with a copy of its most recent Notice upon my request.

Please sign and return a copy of this Notice to RCCSMA.

Patient Name: _____
(Print)

DOB: _____

Patient Signature: _____

Name(s) of others authorized to discuss or request medical information:

_____

_____

_____

_____

RCSM
RESPIRATORY CARE
+ SLEEP MEDICINE

Phone 904-253-6910 Fax 904-253-6964

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Date of Birth:_____
Home Phone:_____ Cell Phone:_____
Address:_____ City/State/Zip:_____

PLEASE NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

◆ **This information may be disclosed and used by the following individual or organization:**

Release To:_____
Address:_____
City/State/Zip:_____
Phone:_____ Fax:_____

◆ **Above listed patient authorizes the following healthcare facility to make record disclosure:**

Facility Name:_____ Facility Phone:_____
Facility Address:_____ Facility Fax:_____
City/State/Zip:_____

- ☐ Complete Records
- ☐ Billing Records
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Radiology Reports
- ☐ Labs Reports
- ☐ Sleep Studies

Other: _____

_____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated on this authorization unless other dates are specified.

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

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and understand that the revocation will not apply to information that has already been released in response to this authorization.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____
Patient/Legal Guardian Signature Date:

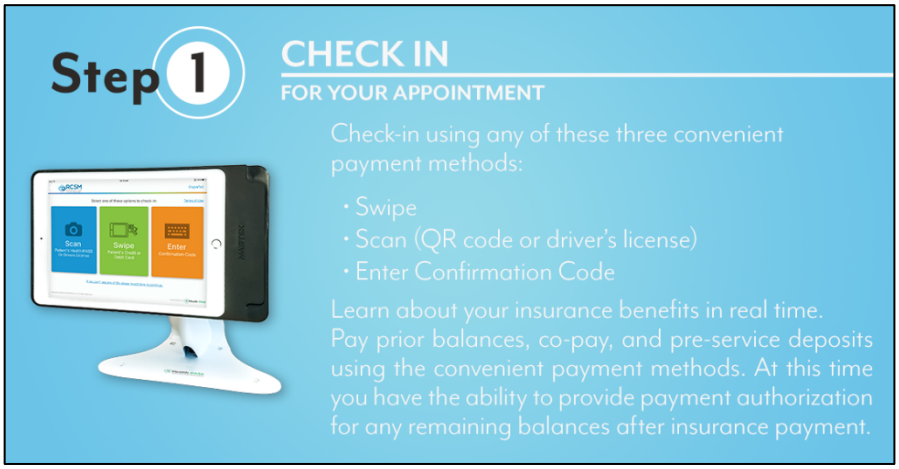
_____ _____
Printed Name of Patient/Legal Guardian Relationship

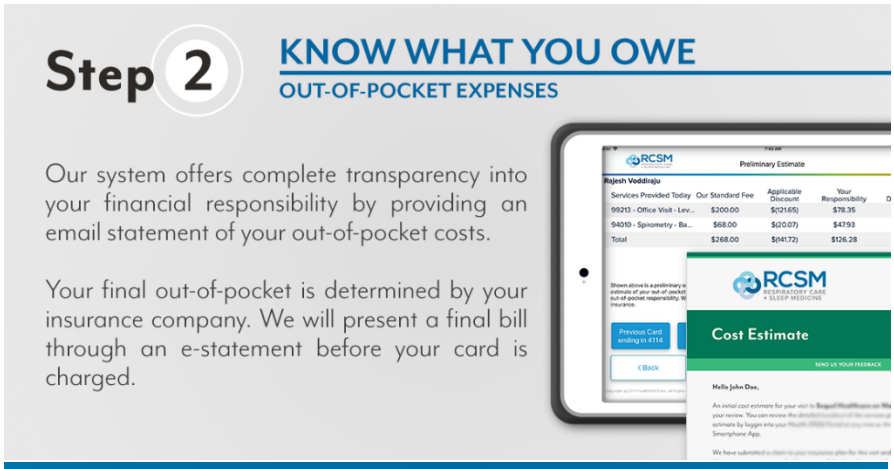
Check-In and Payments are as Easy as 1, 2, 3!

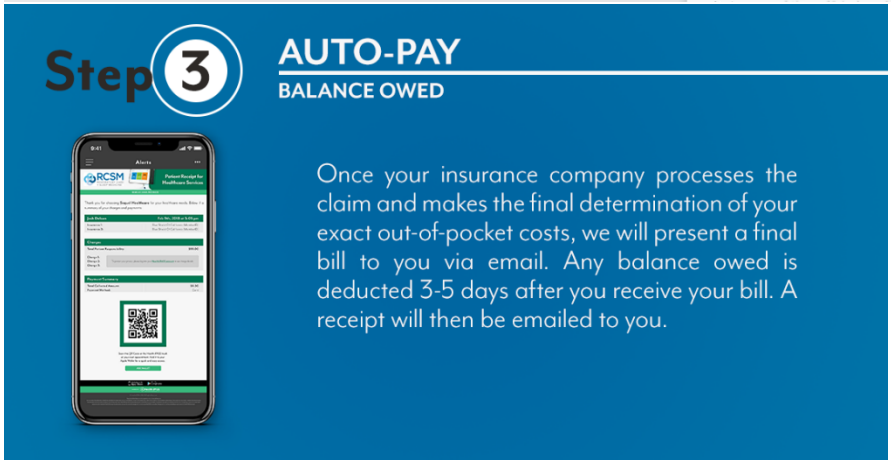
With Health iPASS, managing appointments and medical costs for you and your family has never been easier!

Health iPASS allows patients to enjoy a fast and easy check-in experience at RCSM. Our system gives you the ability to see your insurance benefits and provides a summary of your financial responsibility at the time of your doctor's visit.

With Health iPASS, you can expect price transparency into your cost of care, a convenient end-to-end experience, and peace-of-mind right at your fingertips!







Health iPASS Frequently Asked Questions

In an effort to simplify your experience when receiving care and to make the payment process transparent and convenient, we are introducing the new Health iPASS Patient Check-In and Payment System.

1. How will I receive my check-in information?

Five days before your visit, you will receive an appointment reminder call, text or email.

2. What is the card-on-file system?

This payment program will securely store your credit/debit/HSA payment information “on-file” with Health iPASS for today’s visit only. Once your insurance company processes the claim, you will receive an email notifying you of any remaining patient balance from today’s visit. We will automatically deduct that balance from the card-on-file five business days later.

3. Is my information protected?

Absolutely! Your credit card information is safe and protected. All financial information is fully encrypted maintaining compliance with all the HITECH and HIPAA standards. We do not store your credit card information at any of our locations. We use World pay to process our payments. The same company Amazon and Walmart use.

4. How long will you store my payment information?

Once today's visit has been paid in full, this arrangement expires, and your credit card information will no longer be kept on file. After your insurance has processed the claim, you'll receive the final patient responsibility (out-of-pocket) amount and payment due date via email. If there is any outstanding balance, that amount will be charged using your chosen payment method on the due date and a receipt will be emailed to you.

5. How much will I be charged?

You will only pay what you owe for this visit after co-pay and insurance. You will not be charged again once your post-insurance balance for this visit has been collected.

6. How will I know when I will be charged?

You will receive an email notification indicating the amount owed and date of the transaction after your insurance company has paid the claim. A final transaction receipt will then be emailed to you for your records.

7. What if I decide to change the payment arrangement?

You can make alternate arrangements such as changing the payment type or requesting another payment plan by speaking with an office representative.

Thank you for choosing RCSM for your healthcare needs!

RCSM
RESPIRATORY CARE
+ SLEEP MEDICINE