RESPONSIVE
INFECTIOUS DISEASES SOLUTIONS

Robert A. Zajac M.D., P.A.
Stoneterra Medical Plaza
150 E. Sonterra, Suite. 170
San Antonio, Texas 78258
Telephone: 210-481-2800 Fax# 210-481-2834

Patient Agreement

As a patient of Dr. Zajac, I acknowledge that it's my responsibility to manage my health care and attend all scheduled appointments, take all medications as directed, and have all blood draws requested by the doctor. I also realize that falling short of these necessary tasks may result in the denial of a prescriptions, diagnostic services orders, and possible termination of care.

I also understand that I am financially responsible for my medical care. I understand that copays, co-insurance and deductibles are due at the time services are renderred. Dr. Zajac's staff will inform me about what my insurance will cover, the amount that will be my responsibility and what will be be billed to my insurance. I understand that the benefits information I receive from Dr. Zajac's staff is an estimation and not a gaurantee of payment by my insurance company. I understand that insurance verification and/or pre-authorization is not a promise of payment by my insurance. For those treatments that my insurance is known not to cover, I will be provided advanced notice. I understand and agree that I am ultimately responsible for the balance of my account for any professional services provided to me.

No Show Fee $25.00- notify us of cancellation 2 business days in advance

We spend a great day of time obtaining your records and lab/ x-ray results from hospitals, doctors, and other providers so that your visit with Dr. Zajac is productive and beneficial to your health needs. When you do not come in for your appointment, our effort in preparing your visit is not compensated by your insurance.

After Hours Charges -- $25

Phone calls to the Providers after hours should be reserved for urgent issues only. There will be a charge of $25 added to your account for payment. These fees are not billed to insurance. We ask that you work with the clinic staff during regular business hours, use the patient portal or leave a message for the staff in order to prevent after hours services.

*FMLA paper work is now $30.00 - please give our office 3 business days to complete the forms

HIPPA notice

We will protect your health information and maintain confidentiality. Please see below how and under what circumstances your information will be shared with other parties.

At times, we may be required to release records under the following circumstances: public health agency request, federal agency request, lawsuit with court order, employer if a worker compensation case, federal officials in the event of an audit, and law enforcement requests with subpeona.

When we make a referral to another Provider or level of care, your medical information will be shared with that Provider so that your health care can proceed smoothly. We will use your information to contact your or your MPOA / designate to check on your health status and future needs.

When we communicate with your health insurance, we are required to share some of your medical information such as diagnosis and plan of care in order to obtain approval for treatment. Your protected health information will also be used as needed to obtain payment for services rendered.

When we arrange for services to this organization, such as utilization of an Electronic Health Record management system, your medical information will be managed in an encrypted manner. Similarly, other entities such as an accreditation review organization, a paging service, or a Billing Agency may also have access to some of your data, and it will managed with utmost care and highest privacy standards.

We will not use your protected health information for any marketing activity. At times, a new treatment option may become available for your condition, and if so, we will notify you first before offering any information about you to a third party.

You may request a restriction on our use or disclosure of your health information to certain parties. Please advise us if you wish to place a restriction on your medical record. You may request a copy of your health information and we will charge a processing fee. You may request we update your health record with current information and we will do so. You may adjust or revoke authorization of how we share your information. We will follow your requested preferences to the extent possible while complying with State and Federal Regulators and the routine management of business operations.

By signing, you acknowledge you have read, understand, and agree with the above statements.

Signature_____ Date:_____