Patient Guideline and Patient Financial Policies

_____1. **Prescription Refills:** It is our policy that you should be responsible to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit. This includes all mail-order prescriptions. We cannot take weekend, walk-in, after hours, or phone call refill requests.

_____2. **Information:** You agree to provide your correct name, current and correct address, cellular or other phone number, insurance information, driver's license, or other picture identification at the time of registration or as requested by the practice at any time.

_____3. **Financial Responsibility:** By these initials and your signature below, you accept financial responsibility for all charges for services rendered to you. If a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability.

_____4. **Payment Methods:** We accept cash, check, and several major credit cards. Reception staff may be contacted regarding credit cards accepted or insurance companies in which the practice participates.

_____5. **Appointments/Patient Discharge:** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours [or the Friday before a Monday appointment] notice of cancellation as a courtesy to other patients seeking services. A fee of $25 will be charged for non-cancelled and missed appointments. A pattern of non-cancelled missed appointments may result in discharge from the practice. Please note that discharge may occur for failure to meet your obligations under this document, as well as failure to comply with treatment plans as outlined by the provider.

_____6. **Medical Records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record. The fee schedule is available upon request.

_____7. **Insurance Copayments, Deductibles, and Coinsurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, and coinsurance, or non-covered services are to be paid in a timely fashion. For all newborn patients, there is a 30 day grace period in which child is covered under mother's insurance. Proof of insurance is required after the 30 day grace period, if no insurance is provided a refundable deposit fee of $60 will be applied. Refunds may take up to 1-3 months.

_____8. **Collection and Bank Fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees, and court costs. In addition, banks charge for checks that do not clear or cannot be cashed. You agree to be liable for all such fees with minimum charge of $35.

_____9. **Insurance Claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event that your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all the terms of this policy and by my initials and my signature below, I attest that I fully understand each item and agree to the terms above.

Signature:___________________________________ **Date:**_____________________________