PAYMENT & POLICIES

1. **PAYMENT IN FULL IS REQUIRED AT THE TIME OF SERVICE,** unless other arrangements have been made prior to the office visit. New patients shall pay amount due in full within 30 days of receiving first statement.

2. **Patients** will be responsible to keep the account current. This includes Work Comp and/or litigation related to auto accidents, divorce, legal separation, personal injury, etc.

3. There are also fees assessed for medical records and completion of forms. Prepayment is required.

4. Knowledge of insurance policy provisions will be the direct responsibility, of each patient in relation to certain HMO and/or PPO coverage. Authorization and referral to doctors outside this primary care office may have limitations/exclusions of benefits within certain HMO and/or PPO policies. If there are questions in your coverage, please direct them to your insurance provider.

5. Secondary insurance coverage shall be the patient's responsibility, with the exception of limited contracted insurance companies through this office. Contracted secondary insurance can only be filed upon the patient's provision of the **EXPLANATION OF BENEFITS, (EOB)** from the primary insurance.

6. Cancellations and schedule changes by patients are best served with as much advance notice as possible. **NO SHOW** appointments on a repeated basis may be grounds for release of medical care from this office, in addition, there will be a fee of $100.00 for any no show to an appointment.

7. EMERGENCY MEDICAL situations for the doctor may necessitate a delay or rescheduling of your appointment. We will make every attempt to run on time.

8. To better serve your medical needs, please address your primary medical concerns at the time of your office visit. Time constraints may require a return appointment. If multiple family members must be seen, there will be an office charge for each family member as appropriate.

9. I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our services providers, now and in the future, may be used as a means to contact me, and that this office and our services providers may leave messages for me manually and by automatic systems such as by artificial or prerecorded voice. I also agree that this office and any service provider may contact me by sending text messages and emails to any phone numbers or email addresses that I have provided. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent should stay effective.

MY SIGNATURE is acknowledgement that I have read the policies and agree to abide by the same. If the patient is a minor, permission is hereby given to the physicians in this office to treat the patient, without the presence of a parent or guardian. Additionally, it provides for the release of medical information including substance abuse (alcohol and drug abuse), mental health and HIV-related information (sexually transmitted disease) for the related physician's treatment and insurance records, if required.

I have been offered the Privacy Act Policy. **INITIAL:_____ DATE:_____**

PATIENT SIGNATURE:_____

OR

PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____

Print Patient Name:_____ DOB_____