



Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy which we request you read and sign.

All patients are required to complete our registration form, provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available.

We accept assignment of insurance benefits as a courtesy to our patients; however the balance is your responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be your responsibility. Please be aware that some services provided may not be covered and may not be considered medically necessary, under Medicare and other insurances. Patients will be responsible for payment in full at the time of visit, unless valid insurance is presented. All copayments are to be paid at the time service s rendered.

Some visits are performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

We ask 24-48 hours to process prescription requests and prescription refills.

If you are calling to make an appointment from a referring physician and your insurance requires a referral to be seen, please allow at least 3 business days prior to appointment to assure we receive the authorization. If you choose to be seen without proper authorization, you will be given a waiver to sign stating you aware authorization has not been received and would like to be seen. You will be responsible for any charges your insurance denies because of un-authorized visit.

There is a fee for copied medical records. We will notify you of the records fee and will require payment in full prior to the release of records. We require at least 5-10 business days to receive records and make copies.

Should you arrive late to your appointment, you may be asked to reschedule or you may have to wait to be seen between or after other patients who have arrived on time.

Unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to \$25.00. Please help us better serve you better by keeping your scheduled appointments.

I, _____ have read, understand and agree to the office policy of.

Patient Signature

Date

Responsible Party

Date

Witness

Date