OFFICE POLICIES

Financial Agreements

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physician's staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, out of network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges.

I understand and agree it is my responsibility to know if my PCP (Primary Care Physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature _____ **Date** _____

Outstanding Balance Policy

It is our office policy that all past due accounts be sent 3 statements. If a payment is not made on the account, a single phone call will be made to try and make payment arrangements. If no resolution can be made, the account will be sent to the ***collection agency and may result in discharge from our practice*****.** **Initials**_____

Missed Appointments

I understand that **24 -hour notice** is required to cancel appointments. If this notice is not given, there will be a **$45 missed appointment charge** assessed to my account. **Initials**_____

Patient Privacy Directive: In our efforts to comply with HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

- List phone numbers that we may leave messages on to confirm your appointments.
  _____
- List phone numbers that we may leave messages on regarding treatments or results:
  _____
- List names and phone numbers that we may **TALK** to regarding **appointments**:
  _____
- List names and phone numbers that we may **TALK** to regarding **treatments or results**:
  _____
- List names and phone numbers that we may **TALK** to regarding **billing and payments**:
  _____
- List an email that we may communicate health information to you with:_____
- List a cell phone number that we may TEXT message health info:_____
- Please provide an emergency contact: Name_____Ph#_____

YOU MUST INFORM US IN WRITING OF ANY CHANGES TO YOUR DIRECTIVES

_____ _____ _____

Printed Name Signed Date