



**PATIENT RESPONSIBILITIES**

**SCHEDULED OFFICE VISITS:** Patients shall notify the office at least 24 business hours prior to scheduled office visit if they are unable to keep their appointment. Failure to notify the office shall result in a \$50 no show fee.

**REFILL REQUESTS:** If you have had an appointment in the last 6 months, please give the office 72hrs to complete your refill request. If you have not been seen in the last 6 months, you must be seen for an appointment before refills can be sent. Administrative measures required for authorization from many insurance plans may require additional time.

**PERSONAL INFORMATION:** Patients must bring their photo ID to each office visit to ensure other individuals are not receiving health care services under another individual's identity. All insurance cards must be presented at check-in, at each visit, to ensure services are billed properly.

**COPAYMENTS DUE AT TIME OF SERVICE:** Patients must pay their co-payment, co-insurance, or deductible amounts at the time of service, as well as any outstanding account balances. An additional billing fee may be applied if all out of pocket responsibility is not paid at time of service.

**REQUEST FOR COMPLETION OF MEDICAL FORMS:** Patients may be required to schedule an office visit with a physician to have certain medical forms completed, such as disability determination, family medical leave, or any other lengthy documents that require a substantial amount of the physician's time to complete. The patient may be required to pay up to \$25 for completion of forms if not willing to schedule a visit.

**FAMILY AND FRIENDS IN THE LOBBY:** Patients are asked to restrict the number of family and friends accompanying them to their office visit to no more than 1 adult. No children are to be left unattended in the lobby or office.

**MEDICAL QUESTIONS:** Patients must allow 48 business hours, for responses to any non-urgent medical questions, or messages left for the nurse and/or physician. Patients should call 911 for any life threatening or emergency medical needs.

**CONSENT FOR TREATMENT AND RELEASE OF INFORMATION** I consent for this provider to render the treatment of primary care. This authorization, or photocopy of same, authorizes the release of any medical information necessary for treatment and/or to process claims for services rendered by this provider. This authorization allows the provider to discuss medical information with my doctor(s) and to perform any life-saving emergency treatment necessary to sustain life, including, but not limited to assisted respiratory support.

Please list any person that may have access to your private medical information:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT PRINTED NAME:** \_\_\_\_\_

If someone other than the patient has signed this form, state name and relationship to patient below:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

