ALL PATIENTS: **Please read each section carefully and initial** *If you have any questions, do not hesitate to ask a member of our staff. This form **is scanned into your medical chart** once you've signed it to indicate that you've agreed to abide by the practice policies. [Request a copy if you need it for your own records]*

A) APPOINTMENT POLICIES: Please Initial to Accept:

1. Although we offer appointment reminders as a courtesy, **patients are responsible for keeping track of all appointments**. We require a minimum of 24 hours' notice when cancelling or rescheduling any appointment and a $35.00 late cancelation fee will be charged for all appointments that are missed or canceled with less than 24 hours' notice. Please note that missing *three* appointments in **24** consecutive months without 24 hours advance notice, is grounds for dismissal from the practice.
2. **Please arrive 5-10 minutes** before your appointment to allow enough time for check-in before you see your provider. If you are 10 or more minutes late for your appointment, we will try to accommodate you but may need to schedule a new appointment, there is a $35 charge.
3. We set aside **40 minutes for all new patient appointments** to allow sufficient time for the provider to review all your details and establish a patient-provider relationship with you. Any new patient who misses their **first** appointment without the required 24 hours advance notice will not be able to make any further appointments.
4. We **strive to minimize any wait time**; however, emergencies do occur in this setting and will take priority over a scheduled visit. In such cases, we would appreciate your patience and understanding, knowing that we would do the same for you.
5. To allow the appropriate time and care for your annual **physical exams**, a separate appointment is required for any acute issues you may be experiencing. The physical exam is prevention focused, not problem focused. If you have a new health problem or other illness(es) that need to be addressed during your physical, the treatment of additional diagnoses may result in additional charges.
6. The providers at our office **do not determine long term disability** for any of our patients. However, we are able to refer you to a specialist who could see you for this purpose.
7. We **do not manage Worker's Compensation** issues but can refer you to the appropriate provider.
8. This facility upholds a strict anti-violence policy. Patient and staff safety is a priority and aggressive behavior is not acceptable. Also, if a patient possesses any items used for personal protection (*such as a knife, gun, mace, taser, etc.*) please leave those at home or locked in your vehicle during your visit.

B) MEDICATIONS/PRESCRIPTION REFILL POLICIES: Please Initial to Accept:

PLEASE NOTE:** ***Just as we cannot treat an illness over the telephone, we cannot prescribe medications over the telephone.

1. All patients need to allow **72 hours** (3 business days) for us to process prescription refills. Please plan accordingly as renewals and refills are handled Monday through Friday between 9am and 4pm. Same day refill requests will not be processed.
2. **Call your pharmacy** if you need to refill a non-controlled medication and have them submit an electronic refill request if your renewal is due.
3. Please bring your prescription bottles and any over-the-counter medication to your first visit and have an updated medication list available at every subsequent appointment.
4. Strictly no refill requests or adjustments will be handled after hours or on weekends by our on-call provider. Also, our evening and Saturday hours are reserved only for medical emergency and acute illness. We do not have nurse, prescription, or billing staff available during these hours.
5. Our standard of care requires that patients be seen in our office for us to refill any medications as follows:
   a) *Controlled medications* – patients are seen in our office at least once every 90 days which may vary depending on the individual patient's medication contract, type of medication and dosage as determined by the provider.
   b) *Non-controlled medications* – at least every 6 months or more frequently depending on medication and diagnosis as determined by the provider.
6. Any patients who need controlled medication will be required to sign a medication contract which is updated at least once a year.
7. Urine drug testing may be performed at random intervals and at the discretion of the provider prior to prescribing any controlled substance medication. DEA Regulations also require frequent urine testing, and this is in no way a judgment on the individual.
8. No controlled substances will be prescribed for any patients who test positive for illicit drugs.
9. Please note: We **do not prescribe suboxone or methodone** at this medical facility.

C) FINANCIAL & BILLING POLICIES: Please Initial to Accept:

The Patient Financial Payment Policy has been developed to help our patients understand their financial responsibilities related to their healthcare and to answer any questions regarding patient and insurance responsibility. If there are any questions regarding your health care benefits, you should contact your health plan with the phone number located on your insurance card.

1. **We are required to collect all copays and deductibles at the time of service,** in accordance with our contracts with insurers. Please plan accordingly. A $10 service fee will be applied to all copays and deductibles that are not paid at the time of service.
2. **Patients without insurance are expected to pay in FULL** at the time of the visit unless prior arrangements have been made.

3. For all scheduled appointments, **please expect to pay outstanding balances at your visit,** before being seen.
4. We accept cash, check & credit card (*credit or debit*) payments. Credit card payments can also be processed by phone or electronically through the secure patient portal.
5. A $25.00 fee will be charged for any check returned for insufficient funds and we do not accept post-dated checks.
6. If any balance remains after your initial payment at your scheduled visit and a statement is sent, your **payment is due within 3 weeks** of the receipt of your bill.
7. If prior payment arrangements have *not* been made with our billing office, any account balance outstanding longer than 60 days will be charged a $10.00 late fee. Any balance outstanding for more than 120 days is grounds for dismissal from the practice.

D) INSURANCE PLAN POLICIES: Please Initial to Accept:

Your health insurance plan is a contract between you and the insurance company. We are not part of that contract. As the patient, it is your responsibility to understand your insurance benefits and coverage and the guidelines and limitations set forth by your insurance. Please note: Certain health plans require that specific routine tests and screenings be performed, which may or may not result in an extra charge to the patient.

1. It is your responsibility to **check if we are participating with the insurance you are choosing and that we are in network with your plan**. The list of insurance plans we participate with is updated as necessary and posted at our front desk and on our website.
2. It is your responsibility to **provide us with your current insurance card prior to being seen <u>at each office visit</u>**. This is imperative for us to be able to bill your insurance on your behalf.
3. If your insurance plan requires you to choose a Primary Care Physician it is your responsibility to inform them of your chosen doctor. Failure to do so will result in denial of your claim(s) and you will be responsible for any unpaid visit.
4. It is your responsibility to understand your insurance plan's covered services and participating laboratories. For example,
   a) Not all plans cover *sports physicals*, *hearing screenings, EKG, spirometry, shots, freezings, biopsies*, etc. If these are not covered, you will be responsible for payment.
   b) If you have a high deductible plan, any additional treatments or services done may be applied to your deductible.
   c) Some plans require the use of specific participating labs. If you have labs done by a non-participating lab you may incur additional lab fees.
5. In most cases, we must approve the need for a specialist <u>before</u> an appointment is made or before a procedure or test is scheduled. It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. Per your referral notice from our office, it your responsibility to check whether your health plan is in network with the referred specialist as their office may hold you responsible for payment.

By signing below …

- *I authorize direct payment to Churchville-Chili Family Medicine of all medical benefits otherwise payable to me/my family member under the terms of my/their insurance. A copy of this authorization is deemed as effective and valid as the original.*
- *I know that I am financially responsible for all charges whether or not paid by insurance. In the event that Churchville-Chili Family Medicine pursues civil remedies against me for the collection of my financial obligations for services rendered, I hereby agree to be responsible for reasonable collection, billing, and/or attorney fees and disbursements incurred by Churchville-Chili Family Medicine.*
- *I authorize the release of any medical information necessary to process insurance claims and/or comply with my health plan audit requirements and I assign benefits (including Medicare) of such claims to this practice. This includes any sensitive information contained therein, such as HIV-related information, substance abuse diagnoses and treatment, mental health related care, etc.*
- *I acknowledge that I have read the above information and have provided information that is true and correct to the best of my knowledge. I agree to the above terms and will notify Churchville-Chili Family Medicine of any changes.*

_____
PRINT NAME OF PATIENT OR GUARANTOR

_____
SIGNATURE OF PATIENT OR GUARANTOR

_____ _____
DATE OF BIRTH TODAY'S DATE

DEPENDENTS
(under age 18 who are also patients at CCFM)

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