
Patient Name: _____ Date: _____
Print First and Last Name

I, the patient, understand that:

- ✓ It is my responsibility to know the benefits covered by my medical insurance. This includes, but is not limited to, referrals [for our office, as well as other outside services (i.e. x-rays, hospitals, etc)], co-pays, pre-authorizations, injections and other medications administered in the office.
- ✓ If a referral is required from my primary care physician, it is up to me to bring this referral to my appointment. Failure to do so will result in my being financially liable for my visit or my appointment will be rescheduled.
- ✓ Co-payment is required PRIOR to service.
- ✓ It is my responsibility to inform the office of any change in my address or insurance information prior to any visit. Failure to do so will make the patient responsible for payment for that visit.
- ✓ All procedure appointments require **48 hour notice to cancel or reschedule**. Failure to do so will result in being charged for the entire procedure. All follow up appointments require **48 hour notice to cancel or reschedule**. There will be a charge of $25 for the first broken appointment and $50 and $75 there-after.
- ✓ There is a 48 to 72 hour turn around time for all letters or notes requested from the doctor or staff.
- ✓ There will be a fee charged for the completion of any disability or medical status forms that are requested to be completed by this office. The fee will be in accordance with time involved and the number of medical records copied. Please ask about this fee when presenting the document to be completed.
- ✓ There is a standard $25.00 fee charged when requesting medical records be sent to a Secondary Institute for a second opinion or consultation.

I acknowledge that I have read and understand the above office policies and conditions.

Patient Signature: _____
Patient Date: _____