

Patient Name _____

DOB _____

OFFICE POLICIES

Please initial each section

Regarding Insurance

_____ As a service to our patients, we will submit all claims on your behalf to your insurance carrier provided we are contracted with your insurance carrier. It is your responsibility to understand your insurance policy. Claims rejected by your plan (due to non-covered benefits, pre-existing conditions, etc- see your policy for details) will be billed to you. If you do not have insurance, choose not to utilize your insurance benefits, or if you do not have a plan that Linden Oaks Medical Group accepts, payment in full will be required at the time of service.

Appointment Tardiness

_____ As our physicians strive to remain on schedule when seeing patients, there are times when they may fall behind. We ask that you arrive at your designated appointment time regardless of whether the physician is on schedule as the variables involved in predicting the precise timeliness of the physician is indeterminate. If you arrive tardy for your appointment, based on the discretion of your physician, you may need to re-schedule your visit.

Missed/Canceled Appointments

_____ If you are unable to keep your scheduled appointment, kindly notify us at least 24 hours in advance so we can accommodate our other patients and to avoid a cancellation charge of \$50.00. If you simply do not show up for your appointment, a \$50.00 charge will be applied to your account. This \$50.00 charge is not covered by any insurance company or third party and will be the responsibility of the patient. On the third no-show, it will be the physician's discretion as to whether a discharge letter will be sent out disengaging you from the practice and giving you 30 days to enroll with a new physician outside of our group.

Past Due Accounts

_____ Statements are mailed monthly. If you are experiencing financial difficulty, we encourage you to contact us right away. In cases where an account is more than 60 days past due or the patient has shown an unwillingness to make reasonable efforts, the account may be turned over to our collection agency, and your care may be terminated. If terminated, you will be allowed 30 days of emergency care and medication refills by your physician. We will make every effort to refer your care to an in-network provider or to a community mental health center.

Payment Due At Time of Service

_____ Deductible, co-payment, or coinsurance is due at the time of service. If you fail to pay at the time of service, a \$10 fee will be applied to your account.

Medical Records

_____ Any notes, forms, letters or copy of your medical record that are requested to be sent to an individual/facility by you or someone on your behalf will require you to complete and sign our release of information document in the office. Please allow up to 30 days to process the request. There is no charge for records to be sent to another physician; however, there is a charge to send to an individual/facility. The charge will depend on the number of pages involved, and it is not a billable fee to your insurance.

Miscellaneous Charges

_____ A \$25-50 charge, which is not billable to your insurance, may be assessed for the completion of forms outside of an office visit. Forms or letters may not be completed same day as requested. The charge varies on the length of the form and the time taken to complete. Please allow at least one week for the physician to review and complete. A \$10 charge may be assessed for rewritten prescriptions if lost or expired.

I, _____, have reviewed the above policy.

Please print

Signature

Date