

## Patient Responsibilities

1. Notify us of any changes in your address or insurance information at the time of change. \_\_\_\_\_
2. Know your insurance policy. Every policy has its own rules and regulations. It is your responsibility to know what your coverage includes, and if referrals are required. If you come without getting proper referrals, this means you become responsible for this service. \_\_\_\_\_
3. We order tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and does not cover. (this includes all lab and radiology tests). \_\_\_\_\_
4. All appointments must be scheduled in advance. A \$50.00 No Show or Late Cancellation fee will apply if you do not cancel your appointments 24 hours in advance or do not show up for your appointment. \_\_\_\_\_
5. Co-payments must be made **at the time services are rendered**: (This is a health insurance requirement). If you are not prepared to make your co-payment when you arrive for your visit, your appointment will be rescheduled. \_\_\_\_\_
6. Pay your bill promptly. If there is financial hardship, please call (301) 589-3324 to speak to someone in the billing department immediately.
7. There is a fee for copying medical records. It is a \$22.09 processing fee plus \$.73 per page plus postage. Records may take up to 14 days to process so allow plenty of time when requesting records. \_\_\_\_\_
8. There will be a \$32.00 charge for all returned checks \_\_\_\_\_
9. If your doctor orders tests for you, please schedule another appointment for follow up. To protect your confidentiality, results will not be discussed over the telephone.
10. Prescription refills of any kind will require 48 hours from the time of your call to process. Please do not call after hours to request refills as the doctors do not have access to your records.
11. If you require disability forms, or any other forms, completed, there will be a fee of \$25.00 per each occurrence. Forms will be completed within one week after they are received by our office. \_\_\_\_\_

I \_\_\_\_\_ have read and understand the above policies.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_