THE PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

1. I have the right to be seen in a timely manner. I will be informed of any unforeseen delay and have the right to reschedule if the delay is too lengthy.

2. I agree to be on time for my appointments. I may be asked to re-schedule if I am late in arriving.

3. I agree to give 24 hour notice to cancel an appointment; otherwise a fee may be charged depending on appointment type.

   - First missed appointment: I will receive written notification, and ***may*** be charged $25 or $50 depending on length / type of appointment.
   - Second missed appointment: I will receive written notification of second missed appointment, and ***will*** be charged the appropriate fee, as above.
   - Third missed appointment: I ***will*** be charged the appropriate fee, and I ***will*** also be discharged from the practice.

4. I agree to take prescribed medications only as directed. If I don't understand the directions, I will call the office for clarification. (Please give 24-hour notice for refills.) Refills should be requested by contacting the pharmacy to have them send an electronic refill request directly to us. I can also request refills through the patient portal.

5. I will be informed of any abnormal test results and may view them through the patient portal. (This may require an appointment to discuss treatment options).

6. I will pay my co-payment, if I have a co-payment, at the time of appointment. Co-pays are due at the time of my appointment per my insurance contract. If the copay is not paid at the time of check-in, the appointment will be rescheduled.

7. I will make every effort to understand the benefits of my insurance plan, even to the extent of calling the benefit coordinator at my place of employment, or calling the insurance carrier directly.

8. I will cooperate with the office to assure prompt payment for the services I receive, including those services not covered by the insurance company.

9. I agree that I am ultimately responsible for payment of services I receive and the office is billing the insurance carrier on my behalf.

10. I agree to pay a $35.00 charge for any check that is returned by my bank for any reason.

11. If I fail to pay my bill in a satisfactory manner and the account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees.

12. I agree that this office can only bill a diagnosis documented in my medical record. To ask you to change a diagnosis for the purpose of securing payment from my insurance carrier may be asking you to commit an act of fraud.

_____ _____

Signature of Patient or Responsible Party | Printed Name of Patient or Responsible Party

_____ _____

Witness | Date Signed