**A Notice to Our Patients Regarding Our Office & Financial Policy**

Thank you for choosing Gainesville Family Practice as your primary care provider. In an attempt to keep our patients informed and to insure proper reimbursement for services rendered, we ask that you carefully review the following instructions. By working closely together toward this goal, we can provide you with better care and avoid confusion in the future with regard to your charges.

**Office Policy**

**Appointment scheduling:** We will try our best to schedule your appointment at the most convenient time possible. As a courtesy, we attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to **arrive for their appointment on time**. If you are more than 20 minutes late, we will have you reschedule.

**Lab Work**: To allow our phone lines to be available for incoming callers, please allow our office to contact **you** with laboratory results. If you do not hear from our office within 10 business days, we encourage your call to inquire. If you have a question regarding a bill for laboratory services, please call the number listed on your bill.

**Referrals**: Please allow 5 business days for referrals. Referrals will not be issued after the appointment date.

**Emergency Phone Calls**: We ask that only emergency phone calls be placed to our “on-call” physicians. Those patients choosing to call the physician with non-emergency complaints may incur a fee of $ 15.00 (i.e., runny nose, etc.)

**Medication Refill Requests:** We ask that you contact your pharmacy directly to request a refill of your medication. Please allow 36-72 hours for a response on all refill requests. Please plan ahead so that you do not run out of your medication. Any expedited requests will incur a $15.00 refill fee.

**Forms and letters**: Finally, because of the volume of paperwork associated with managed care, our office must charge a fee of $15 for form completion and custom letters. We must have a one-week notice for these requests.

**Financial Policy**

**Payment for services**: Our office accepts cash, checks, Visa and MasterCard, Discover, and American Express as forms of payment.

**Insurance coverage**: We currently participate with a number of health plans. This does change periodically. Therefore, you always should contact your insurance company to confirm our continued participation of In or Out of network benefits. By signing the necessary forms at the time of your registration, we can file your insurance claims for you. **Knowing your insurance benefits co-pays and deductibles are your responsibility**. Please be aware that as medical providers, our relationship is with you and **not your insurance company**. **Problems relating to your coverage should be handled between you and your carrier.**

**Co-payments and deductibles**: Co-pays are required at the time of your visit. If you do not have your co-pay at the time of your visit you may be rescheduled and may be charged an additional fee for MISSED APPOINTMENT for that day. Balances are also collected at the time of visits. If we have to bill you for a required office co-pay, there will be a $25.00 service charge added to your account.

**Non-covered Services**: Please be aware that some of the services you receive may be considered non-covered or not medically necessary by your health plan. You will be financially responsible for these charges.

**Proof of insurance**: All patients are required to present a valid insurance card along with a copy of your driver’s license or other state identification at every visit. If proof of insurance is not provided at the time of service, all claims will be billed to the insurance currently on file at the office, and may request you pay for your services until you can provide it.

**Claim submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. At times however, your insurance may require additional information from the patient and /or the subscriber. Failure to provide additional information may result in the outstanding balance becoming your personal responsibility.

**Coverage changes**: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you maximize your benefits.

**Nonpayment**: All outstanding balances are to be paid upon receipt. Payment is required for past-due balances prior to your next visit. After four (4) statements your account will be forwarded to our collection agency for further collections and you and your immediate family will be dismissed from the practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. There is an additional charge of 30% of the outstanding balance associated with collection actions that will be the responsibility of the patient.

**Walk-in appointments**: Any patient that walks in requesting a same day appointment may incur an additional $50.00 fee if the provider’s schedule must be adjusted to accommodate. This payment is expected prior to seeing the provider and is not reimbursable by insurance. Our Practice is not a walk in clinic.

**Cancellation & No shows**: Cancellations must be received 24 hours in advance. This fee can range from $50-$75, depending on the appointment type. This fee is not reimbursable by insurance. We require a 3 hour notice of cancellation for a sick/regular office visit. Preventative services, pre-op exams, school/ camp physicals are allotted longer time slot availability.

**Self-Pay patients:** If you do not have insurance coverage, **charges must be paid in full at the time services are rendered**.

**Returned checks:** If for any reason a check is returned on your account, you will be responsible for a $50.00 returned check fee in addition to the original fees for services.

Signature of patient/ Responsible party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Updated 04/04/2016*