Post Falls Family Medicine, P.A.

Office Policies

Release of Information

I (we) the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patients' medical records to any entity, which is, or may be liable for all or part of the provider charges.

I (we) authorize the release and disclosure or any and all medical records to any other entity including by not limited to referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office, in providing for the treatment of patient.

I (we) authorize the release of records necessary as assist in reimbursement of benefits to which I (we) may be entitled. I (we) authorized this office and/or its employees to release via fax machine medical records which are needed in order to provide patient with the most appropriate medical care.

I (we) authorize the release of my x-rays, labs and medical results to be left on my answering machine if I am unavailable. Yes____ No_____

I (we) the undersigned patient and/or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Financial

Post Falls Family Medicine, PA is happy to bill our patients insurance carriers as a courtesy when they present with a current insurance card, however, we are not contracted with all insurances nor do we know your individual policy, so please contact your carrier before you are seen to verify your benefits for services you may receive. It is ALWAYS the patient's responsibly to know their insurance carriers benefits and polices.

Lab

Post Falls Family Medicine offers on site lab services for the convenience of our patients. Post Falls Family Medicine bills for insurance types: Asuris, Blue Cross, First Choice, Group Health, Premera and Regence. LabCorp bills all other insurances. If you have any questions about your lab services that LabCorp has billed please feel free to contact their billing department.

Agreement to Pay for Treatment

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with which this office has a contractual agreement, the patients and/or responsible party also agree to pay for treatment rendered to patient. In the case of non-payment by contracted carrier, patient is ultimately responsible for payment and follows up with carrier for series rendered.

I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies. In the case of default on payment, I understand that my account may be turned to a collection agency along with possible termination of care with this clinic.

No Show/Missed Appointment Policy

A minimum of **24 hours cancellation** notice is required for appointments; enabling us adequate time to offer the cancellation slot to another patient. If less than 2-hour cancellation is given, the appointment becomes a "missed" appointment. If you fail to show up at all for your appointment, it will be considered a "no show" appointment.

After the first "no show/missed" appointment, you will receive a letter from our office notifying you that the missed appointment will be recorded as such in your chart.

If you incur a 2nd "no show/missed" appointment, with in a one year time period, you will receive a letter from our office notifying you that you have been charged a $35 missed appointment fee. **These fees must be paid prior to being seen at your next visit. You are responsible for any no-show fees you are charged; your insurance company will not be billed.**

If you incur a 3rd "no show/missed" appointment within a one year time period, you will received another letter from our office and may face dismissal from the practice at the discretion of the doctor.

I, the undersigned patient, and/or responsible party have read and received a copy of Post Falls Family Medicine's policies.

Signature: _____ Date: _____