

Dr. Nancy Aria - Office Policy Agreement Form

Please read the following office policy information and initial after reading each paragraph

- _____ (initials) I understand that it is my responsibility to provide the doctor with my current and accurate insurance card and a valid referral, if required by my insurance, at the time services are rendered. If I cannot provide my current insurance card and/or referral, my appointment may be rescheduled. Claims that are denied for payment because of incorrect insurance information will become the responsibility of the patient.
- _____ (initials) I acknowledge that if I have a **PPO** plan or **Medicare** a referral may not be required for my visit. I acknowledge that if I have an **HMO** plan, I am required by my insurance company to have an appropriate referral from my primary care physician at the time of my appointment. If I am seen without an appropriate referral, I will be responsible for any non-covered services.
- _____ (initials) If for any reason I need a copy of my records, I acknowledge that this must be requested **in writing** and there will be a record release processing fee. I recognize that it may take up to **TWO WEEKS** for the request to be processed and that most records are not kept beyond six years. Additionally, I understand the office will not complete any workman's compensation or disability forms.
- _____ (initials) It is my responsibility to schedule any recommended testing or procedure and to obtain referrals to other physicians for biopsy, radiology, consultation and/or surgery. I will follow up with Dr. Aria's office to ensure results have been received by their office.
- _____ (initials) I acknowledge that if I do not comply with Dr. Aria's recommendations to have advised procedures (such as radiology, biopsy or other additional testing) performed, I accept full responsibility for any undesirable consequences of my medical condition.
- _____ (initials) I understand that if I have TRICARE as my primary insurance, Dr. Aria's office will not submit to any Tricare secondary insurances. Dr. Aria's office will provide me with the coded receipt necessary to submit to a secondary insurance on my own. Dr. Aria's office will submit to Tricare at the time of service. If I am unable to wait for the claim to process, I will leave a credit card on file.
- _____ (initials) I understand that if I need a refill on a prescription, I will contact my pharmacy and ask them to fax a written request to the office. I recognize that it may take two days for processing, and if I request this process to be expedited, there will be a \$25.00 fee. If I have not been seen within one year of receiving the original prescription, I will need to be re-evaluated. If I lose my original prescription there is a \$10.00 lost prescription fee and I must come into the office to pick it up.
- _____ (initials) **Per my insurance company, co-pays must be collected at the time of service. Payment is preferred to be made in the form of cash or personal checks.** Health benefits cards are also acceptable. I am aware that my insurance plan may be subject to a deductible for procedures, such as freezing/biopsies/ sonograms. Balances of less than \$10.00 may only be billed once a year. If this presents any inconvenience, the office is happy to keep your credit card on file and charge once the balance is due.
- _____ (initials) If I fail to show up to my appointment without giving the office 24 hours notice of cancellation, I am aware that there is a \$25.00 cancellation fee.

I have read and understand the above information.

SIGNATURE: _____ DATE: _____

Relationship to Patient: _____