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NAME_____

OFFICE POLICIES-

The following is a statement of our office policies that we request you ***read, initial and sign*** prior to any treatment.

INITIAL

_____**Health history form:**
In the patient's best interest, our Patient Information and Health History Form must be completed before seeing the doctor.

_____**Billing Information:**
We have contracted with an outside billing company to handle all of our billing for our office. If you call our office with any billing questions, you will be referred to our billing company. We cannot access your billing records from this office.

_____**Payment of Account:**
If you do not have insurance, or if we are not contracted with your insurance company, then full payment is required at time of service. As a professional courtesy, we will submit claims to your insurance company (ies) however; **we do require your co-payment or deductible at the time of service.** Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your claim in full within **60** days the balance of your account will be your responsibility to pay.

If your co-pay is not paid at time of service or your balance due is not paid after you receive your first statement, **$25.00** will be added to your account. A **$25.00** fee will be charged on any check that is returned for insufficient funds.

_____**Compliance:**
The doctor and the staff will be providing you with top-quality professional care and it is your responsibility to follow the doctor's directions regarding your medical treatment. If you are unable or unwilling to do so, it may be necessary to have you establish with another physician.

_____**Courtesy to Dr. Bernard's Office Staff:**
Our Staff has your best care and concern at heart. Please be courteous to the health care team that works with Dr. Bernard. If you have any problems with a staff member please bring it to Dr. Bernard's attention at the time of the event or put it in writing with specific details.

_____**Prescription Refills:** If you need a prescription refilled, **please call your pharmacy.** If you have no remaining refills, the pharmacy will then contact our office. There will be a $45.00 charge for each Rx not asked for while at your appointment.

_____**Lab and Test Results:**
Our office usually receives results within one week after you have the tests completed. If the results are **abnormal,** we will contact you by phone and/or schedule you an appointment to discuss results. **To eliminate the overload of office calls, we ask that you do not call the office any earlier than 7 days after you have had** the tests done.

_____**Missed Appointments:**
We require at least a 24-48 hour cancellation notice. **The reminder call that our office makes to you is a "courtesy" call. It is your responsibility to know when your appointment is**. Missed appointments add to the overall cost of care, as trained personnel and medical services are not being utilized. The no-show fee is $150.00. Please help us serve you better by keeping your appointments.

_____**We have your consent to check your external prescriptions history.**

_____We **are NOT Medi-Cal Providers.**

Thank you for understanding our Office and Financial Policy. Please let us know if you have any questions or concerns.

I have read the above Office and Financial Policy, I understand and agree to these policies.

_____ _____
Signature of Patient/Responsible party **Date**