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ONGOING OFFICE POLICY-2018

MISSED VISITS/NO SHOWS FOR ESTABLISHED PATIENTS

We need at least one hour notice of any cancellations or rescheduling or you will be subject to a **service fee of $25.00**. You may leave a message on the answering machine at any time as the calls are time stamped. Service fees are **not** covered by insurance or flex spending accounts.

MEDICARE PART B DEDUCTIBLE

The Medicare Part B Deductible remains ***$183.00 for the 2018 Calendar year***.

COPAYS/FEES

Your copay is due upon check in at the window before your visit. Any fees not covered by your insurance are due upon checkout. If payment is not received on the date of service, there will be a service charge of **$5.00** added to your account, which is not covered by your insurance company or flex spending accounts.

SICK LEAVE/DISABILITY/FMLA FORMS/JURY DUTY/MISCELLANEOUS LETTERS OR FORMS

There will be a **$10.00-$30.00** charge for filling out any forms or typing any letters, this is not included in your office visit fee. Please allow up to one week for these to be completed. You must pay for your form/letter at the time of your request for same. These are **not** covered by your insurance or flex spending accounts.

MEDICATION REQUESTS

Medication refills/requests require authorization by your physician, therefore, we require AT LEAST TWO (2) BUSINESS DAYS NOTICE for processing prescription refills/requests.

There will be a **$10.00** processing fee for medication requests between office visits. This will **not** be covered by your insurance or flex spending accounts. ***This fee also applies to any medications being prescribed in between visits or calls requesting changes in prescriptions.***

Sorry, we do not fill prescriptions outside of business hours or on weekends and we do not start any new medications outside of an actual patient visit. We also urge you to carefully check your prescription to be sure that the correct medication was filled by the pharmacy.

I have read and understand the above ongoing office policy.

SIGNED_____**DATE**_____

NOTICE AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices provided by HAROLD F. ROTH, D.O.

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PATIENT NAME (PLEASE PRINT)

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SIGNATURE OF PATIENT OR GUARDIAN **DATE**