Patient Responsibility Consent Form

* $25 Same day cancellation/No Show fee

As a provider’s office we try to accommodate our patients as best as we can. Same day cancellations prevent us from scheduling other patients that may need to come in. As a courtesy, our office calls to confirm appointments the day before but appointments remain patient responsibility. We ask for at least a 24 hour notice when cancelling otherwise a $25 same day cancellation/ no show fee will be accessed. **NO EXCEPTIONS.**

We also acknowledge there may be dates that the practice will be closed or physicians may be out of the office and we’ll have to cancel patient appointments. For these circumstances we will make it a priority to cancel these appointments in a timely manner.

* Referrals

It is the **patients’ responsibility** to know if their insurance requires a referral and to obtain the referral from their PCP (both for initial visit and follow up appointments). A referral through the insurance will be required if you have an HMO plan (or any other plan that requires referrals), meaning there must be an authorization number, approval dates and must be approved by the insurance company. A hand-written referral from PCP will not suffice. If the referral hasn’t been received from the PCP’s office at the time of your appointment, or you fail to bring one in with you, you will have to be rescheduled. This also applies to patients who are currently insured through PPO plans that may later switch to a HMO plan. **Please keep in mind that claims will be denied by insurance for no referral on file, resulting in patient being responsible for entire balance.**

* Outstanding Balance

Outstanding balances and office visit payments are due prior to seeing the doctor. We verify insurances before your office visits. This only includes co-payments and will not include Injections or other procedures done in office during your visit. These extra charges will be billed and it will be patient responsibility if insurance does pay/cover.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand and accept my responsibilities as a patient.

(Print Name)

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_