Bay Area Chest Physicians, P.A. Office Policies

Patient Name: _____DOB: _____

Thank you for choosing Bay Area Chest Physicians, P.A. for your healthcare needs. We recognize that you have a choice in healthcare providers, and we appreciate the trust that you have placed in us. The following information details the office policies that allow us to provide excellent health care to each patient in an office atmosphere that is based on mutual respect. Please review and sign in the designated area that you have read, understand, and agree to abide by our office policies.

On your first office visit appointment and all subsequent visits in which you will be providing insurance information we ask that you arrive 20 minutes prior to your scheduled appointment time. This will allow time for you to complete the New Patient registration process or update your insurance information. We will obtain a photocopy of your current insurance card and picture identification. Demographic updates will be obtained every 6 months and medication lists are verified at each appointment.

We respect your time and try our best to stay on schedule but occasionally a patient requires more time than allotted due to an urgent or complicated medical problem. Thank you for understanding that we will provide the same level of attention to you in the event you have a complicated medical problem.

If you are more than 15 minutes late for your scheduled appointment, your appointment will be rescheduled.

Our office requires 24-hour notice for all cancellations. This will allow us time to contact another patient who needs medical care. All New and established patient appointments that are NOT cancelled with a 24-hour notice will result in a $50.00 fee being accessed to your account. As a courtesy, we do provide appointment reminders via emails, phone calls, and text messages 2 days prior to your appointment. However, it is your responsibility to know your appointment date and time.

I understand if I do not show for two consecutive appointments, no show for a total of three appointments or cancel for a total of four appointments, I may be discharged from care. If this unfortunate situation occurs you will be notified in writing, via certified mail.

You may be asked to schedule another appointment if you are scheduled for a routine appointment or hospital follow-up and another medical issue arises other than the reason for your original appointment such a surgical clearance.

All co-pay's will be collected prior to each appointment. In the event you do not have payment on the day of your visit, your appointment may need to be rescheduled. Any outstanding balances on your account for deductibles, and co-payment/co-insurance as determined by your insurance carrier will be collected prior to your appointment with the provider. You are responsible for all amounts not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for your balance in full. I understand that it is my responsibility to provide accurate and complete primary and secondary insurance information prior to my appointment. I authorize my insurer to pay any benefits directly to Bay Area Chest Physicians, P.A., for the full and entire amount of the bill incurred by me or the above-named patient.

Physicians may order laboratory studies, imaging studies or procedures that are necessary to make medical diagnosis or to appropriately manage a medical condition. We do not order unnecessary tests. It is your responsibility to understand your insurance policy, benefits, and coverage.

After your appointment with the physician or PA you will be asked to go back to the waiting until the provider can complete your visit note. Once that visit note is completed with follow-up instructions, tests ordered, and prescriptions sent you will be called back to the checkout counter where the final details of your appointment will be completed.

Routine prescription refills will be given during office hours only. Please contact your pharmacy to have a refill request sent electronically to our office. Please allow 3 business days for your request to be refilled.

I have read, understand, and agree to abide by the office policies described above. the.

Patient Signature _____Date _____

Guarantor Signature _____Date _____
(If guarantor is not the patient)

Consent for Treatment and Authorization to Release Information

I hereby authorize Bay Area Chest Physicians, P.A., through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment, and treatment procedures.

I further authorize Bay Area Chest Physicians, P.A., to release any information acquired during my or the above-named patient's examination and treatment necessary to pay my claim.

Patient/Guarantor Signature _____Date _____