| **OFFICE POLICIES & PROCEDURES AGREEMENT** |
| --- |

**Date:\_\_\_/\_\_\_/\_\_\_Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Chart#:** \_\_\_\_\_\_\_\_\_

We are pleased to participate in your healthcare and look forward to establishing a lasting relationship as your healthcare provider. These policies and procedures will establish the expectations you will receive from the GALATIANS providers and also what we expect from you as our patient.

**+APPOINTMENTS:**

* We ask that all patients arrive at least 15-20 minutes prior to your actual appointment time. Late arrivals may be asked to reschedule their appointment.
* Failure to submit completed demographic information, appropriate health history or this signed form may result in the rescheduling of your appointment.
* In an effort to provide efficient access to our providers and control costs, ALL patients must CONFIRM ALL APPOINTMENTS or they will be cancelled. If you arrive at our office without confirming your appointment, you will be asked to reschedule your appointment. ***NO CONFIRMATION = NO APPOINTMENT.***
* If a second appointment is missed or cancelled with less than a 24 hour notice, we reserve the right to terminate our provider-patient relationship.

**+INSURANCE:**

* ***Proof of CURRENT insurance coverage must be presented for each family member with an appointment at each visit, if not, you will be responsible for payment in full at the time of your visit to our office.***
* If GALATIANS is not contracted with your insurance company, you are responsible for payment in full at the time of your visit.
* If your insurance requires you to choose a PCP provider, it is your responsibility to ensure you have the appropriate authorization to see the providers at GALATIANS COMMUNITY HEALTH. It is also your responsibility to list us as your PCP if you choose to do so.
* I understand that I and/or the responsible party are responsible for all charges whether or not paid by insurance.

**+CO-PAYS, DEDUCTIBLES, AND FEES:** Co-pays, insurance deductibles and fees for services not covered by your insurance policy, are typically collected at the time a service is rendered. We accept Cash, Visa, MasterCard, HSA and FSA cards.

**+PAST DUE ACCOUNTS:** Payment is due when services are rendered. If we file your insurance and they pay their portion, any remaining balance is your responsibility. You will receive 3 monthly bills from our office. If you have not paid in full or arranged and **honored** a payment plan within 3 months, your account will automatically be referred to a collection agency who will report your past due status to a Credit Reporting Agency. *Your account will also be reviewed for possible termination of our provider/patient relationship due to the inability to resolve your delinquent account.*

**+COMPLETION OF FORMS/LETTERS:**

* A **$20.00 fee** will be charged as patient responsibility for completion of the following forms and must be paid prior to the release of the form(s), including the following but not limited to: Disability forms, FMLA forms, Leave of Absence forms and Home-Bound forms. ***Please allow 7-10 business days for completion of these forms.***
* However, the following forms remain free if brought to your appointment and completed during your scheduled visit: School/Sports Physical forms, return to school/work forms and/or shot records.

**+HOSPITAL / AFTER HOURS CALL COVERAGE:** All emergencies should contact 911 or visit the nearest hospital.

* Pregnant patients: if seen at Rex Hospital - you will be cared for by a WHA Capital Ob/Gyn provider or the appropriate Rex hospital staff. If seen at Wake Med Hospital or any other hospital - you will be cared for by their hospital staff.

***By signing this agreement, you agree to abide by all the policies and procedures stated within.***

| **Signature***(Patient/Parent/Legal Guardian)* |  |
| --- | --- |