HORNER FAMILY PRACTICE

NAME: ______________________________ D.O.B ____________________________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Notice of privacy practices are available at the reception desk. I understand that Horner Family Practice has the right to change its privacy practices from time to time and I may contact Horner Family Practice to obtain a copy of their privacy practices.

INSURANCE

Your insurance policy is a contract between you and your insurance company. We submit the medical services to your insurance carrier. Please be aware that some and perhaps all the services provided may be "non-covered" according to your insurance policy. You are responsible for the payment of these services. By signing this you also authorize Homer Family Practice to release information required in the processing of insurance claims.

MEDICAL INFORMATION RELEASE

You must list the names of all family members and/or other persons we can release information to, regarding your care.

Name: __________________________ Relationship: __________________________

Name: __________________________ Relationship: __________________________

Name: __________________________ Relationship: __________________________

I authorize and give consent to Horner Family Practice to leave messages on my machine:

____ Appointment Reminders Preferred Phone Number: _____________________

____ Medical Information Preferred Phone Number: _____________________

Signature: ____________________________________ Date: ___________________________

CONTINUED ON BACK

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MISSED APPOINTMENTS/LATE CANCELLATIONS: it is the policy of this office to require **24 hours advance notice** for all appointment cancellations to allow the physician's maximum availability for their patients. To ensure availability is managed appropriately, it is necessary for us to have the following policy for missed appointments.

1st missed appointment/late cancellation: Our office will attempt to notify by phone and mail you a letter to reschedule your missed appointment.
2nd missed appointment/late cancellations and all thereafter. There will be a $50.00 charge billed to you, not your insurance company. In addition, you will not be seen until this fee is paid – you also risk the possibility of being discharged from the practice.

BILLING: We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

COPAY: Your copay is due at the time of your visit.

OUTSTANDING BALANCES: Accounts 90 days past due WIll be turned over to a collection agency.

SELF-PAY PATIENTS: Homer Family Practice has a sliding scale policy that may qualify you for a discount. Please ask billing for an application to complete.

FORMS AND FEES: There is a fee for review and completion of all forms. The fee is determined on the form and charges are up to the physician. Payment for forms must be made at the time forms are picked up.

Redeposit check fee: $15.00
Returned check fee: $35.00
Any work/school excuse requires an office visit.

Signature: ______________________ Date: ______________________

CONTINUED ON BACK