

PATIENT REGISTRATION FORM

PATIENT INFORMATION										
Today's Date:				PCP:						
Patient's Last Name:		First:		Middle:		Birth Date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Race:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss		Email Address:		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to specify			
Address:				City:		State:	Zip Code:			
Cell Phone: () ()		<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other _____ () ()			Social Security #: / /					
Occupation:		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Employer:			Employer Phone #: ()				
Chose clinic because/ Referred to clinic by: <input type="checkbox"/> Dr. _____ (Specialty) _____ <input type="checkbox"/> Hospital <input type="checkbox"/> Family/Friend <input type="checkbox"/> Billboard <input type="checkbox"/> Close to home/work <input type="checkbox"/> Internet search/Yellow pages <input type="checkbox"/> Insurance <input type="checkbox"/> Other _____										
Other family members seen here: <input type="checkbox"/> Yes By Dr. _____ <input type="checkbox"/> No		Provider preference? <input type="checkbox"/> First Available <input type="checkbox"/> Yes _____ <input type="checkbox"/> No			Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____					
INSURANCE INFORMATION										
Is this patient covered by Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date effective: _____						
Primary Insurance Company:			Group #:		Policy #:					
Insurance Company Address (on back of card)					Customer Service Phone #: ()					
Who is the Primary Policy Holder?			Patient's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Other _____							
Policy Holder's Date of Birth: <input type="checkbox"/> Self <input type="checkbox"/> ____/____/____		Policy Holder's Social Security #: <input type="checkbox"/> Self <input type="checkbox"/> ____/____/____			Insurance obtained through employer? <input type="checkbox"/> Yes – Employer _____ <input type="checkbox"/> No					
Name of Secondary Insurance (if applicable):			Group #:		Policy #:					
Insurance Company Address (on back of card)					Customer Service Phone #: ()					
Who is the Primary Policy Holder?			Patient's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Other _____							
Policy Holder's Date of Birth: <input type="checkbox"/> Self <input type="checkbox"/> ____/____/____		Policy Holder's Social Security #: <input type="checkbox"/> Self <input type="checkbox"/> ____/____/____			Insurance obtained through employer? <input type="checkbox"/> Yes – Employer _____ <input type="checkbox"/> No					
IN CASE OF EMERGENCY										
Name of local friend or relative (not living at same address):			Relationship to patient:		() _____ - _____ <input type="checkbox"/> Home <input type="checkbox"/> Cell () _____ - _____ <input type="checkbox"/> Other _____					
<p>▪ I hereby certify that I have reviewed the above information and made any necessary corrections. I understand that the above coverage information is what was quoted directly from my insurance carrier and is not a guarantee of benefits. I understand that by signing below I am stating that this information is correct, and I will be held responsible for any services denied for lack of coverage or inability to identify the patient and/or subscriber in the insurance carrier's system.</p> <p>▪ I hereby authorize my insurance benefits be paid directly to The Physicians Spine & Rehabilitation Specialists realizing I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.</p>										
_____			_____			_____				
PRINTED PATIENT NAME			PATIENT SIGNATURE			DATE				

NEW PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Location of Pain: _____ Onset of pain: _____

Description (aching, sharp, burning, etc.): _____

Was the pain caused by an injury? () YES () NO If YES, describe injury: _____

Were you injured at work? () YES () NO Date of Injury: _____ Unable to work due to pain? () YES () NO

What is the status of your claim? () N/A () Retained Attorney () Claim Settled () Currently in Litigation

Have you had any of the following treatments for your pain?

() Physical/ Occupational Therapy: _____ When? _____

() Injections or Nerve Blocks: When? _____ Performed Where? _____

() Surgery: When? _____ Name of Surgeon: _____

() Past Imaging (X-Ray, MRI, CT-Scan): _____ Place of test: _____

Past Medical History: (Personal and Family):

Disease/Condition	Patient History		Family History		Which family Member?
	YES	NO	YES	NO	
Any contagious disease					
High blood pressure					
Diabetes					
Heart Disease					
Kidney Disease					
Liver Disease					
Thyroid problems					
Bleeding disorders					

Other (please specify):

Questionnaire: Mark each box that applies

FAMILY HISTORY OF SUBSTANCE ABUSE		
• Alcohol		<input type="checkbox"/>
• Illegal Drugs		<input type="checkbox"/>
• Prescription Drugs		<input type="checkbox"/>
PERSONAL HISTORY OF SUBSTANCE ABUSE		
• Alcohol		<input type="checkbox"/>
• Illegal Drugs		<input type="checkbox"/>
• Prescription Drugs		<input type="checkbox"/>
AGE BETWEEN 16-45 years		<input type="checkbox"/>
HISTORY OF PREADOLESCENT SEXUAL ABUSE		<input type="checkbox"/>
PSYCHOLOGIC DISEASE		
• ADD, OCD, Bipolar, Schizophrenia		<input type="checkbox"/>
• Depression		<input type="checkbox"/>

Allergies:

Please Check if you have an allergy to: () Eggs-Reaction: _____ () Iodine-Reaction: _____
 () Shellfish-Reaction: _____ () Latex-Reaction: _____

<u>Medication Allergy</u>	<u>Reaction</u>	<u>Medication Allergy</u>	<u>Reaction</u>
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Current Medications: Please list ALL current medications (or provide us a copy of current list)

**Are you taking any BLOOD THINNERS? YES NO If yes, please list below:

MEDICATION NAME	DOSE	HOW OFTEN TAKEN

Surgical History: Please list ALL previous surgeries and dates

SURGERY	DATE	SURGERY	DATE
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Pharmacy Information: Name: _____ Phone #: _____

Address: _____

Review of Systems: Please circle all that apply

Patient Name: _____

Date: _____

GENERAL	EYES	MUSCULOSKELETAL	PSYCHIATRIC
Fatigue	Light Intolerance	Muscle Pain	Depression
SKIN	HENT	NEUROLOGICAL	ENDOCRINE
Skin Color changes	Congestion	Numbness	Incontinence
RESPIRATORY	CARDIOVASCULAR	HEMATOLOGY	GASTROINTESTINAL
Shortness of Breath	Chest Pain	Abnormal Bleeding	Constipation

OTHER: _____

Social History:

Marital Status- () Married () Partnered () Single () Divorced () Widowed

Number of children- _____ Age of children- _____

Current Occupation: _____ () Full-time () Part-time

If unemployed, previous occupation: _____ () Full-time () Part-time

*** Please answer the following questions:**1. Do you have an Advanced Directive? ___ NO ___ YES **If yes, what type?** ___ DNR ___ POA ___ Living Will _____2. Have you received the Influenza Vaccine in the past? ___ NO ___ YES **If yes, when did you last receive it?** _____3. Have you received the Pneumonia Vaccine in the past? ___ NO ___ YES **If yes, when did you last receive it?** _____4. Do you smoke Tobacco? ___ NO ___ YES **If no, did you smoke in the past?** ___ NO ___ YES Year Quit: _____5. Do you drink Alcohol? ___ NO ___ YES **If yes, please answer the following questions:***** How often did you have a drink containing alcohol in the past year?**

___ Never ___ < Monthly ___ 2-4 times a month ___ 2-3 times a week ___ 4 or more times a week

*** How many drinks did you have on a typical day when you were drinking in the past year?**

___ 1 or 2 drinks ___ 3 or 4 drinks ___ 5 or 6 drinks ___ 7 or 8 drinks ___ 10 or more drinks

*** How often did you have 6 or more drinks on one occasion in the past year?**

___ Never ___ Less than monthly ___ Monthly ___ Weekly ___ Daily or almost daily

6. Have you fallen in the past year? ___ NO ___ YES **If yes, how many?** ___ **Were you injured?** ___ NO ___ YES

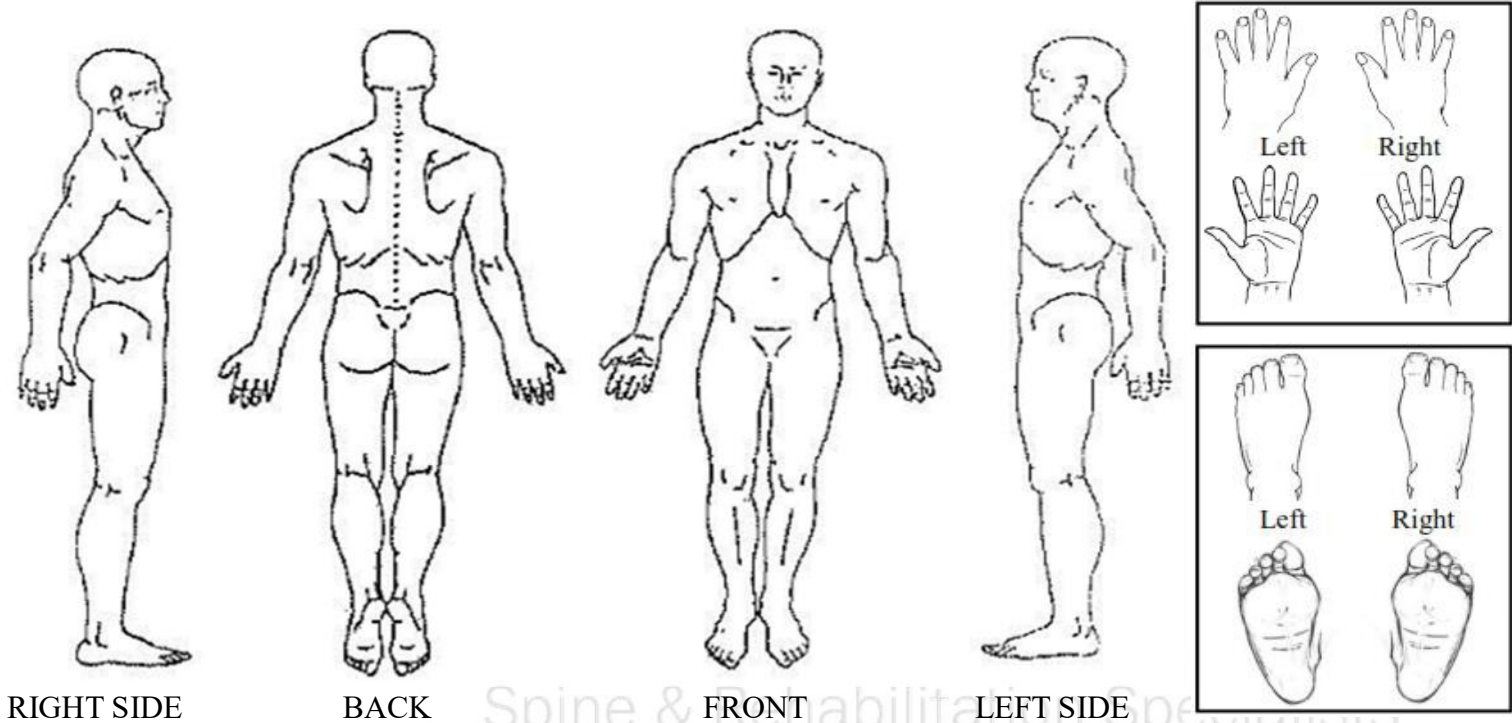
I hereby certify that I have reviewed the above information and made any necessary corrections. I understand that by signing below I am stating that this information is correct to the best of my knowledge.

Patient Signature: _____

Date: _____

Patient Name: _____ Birthdate: _____ Date: _____

Shade the areas where you are currently having pain on the diagrams below



Function and Pain Assessment

Evaluation of current pain interference-- this scale's examples of activities at different levels are not meant to be exclusive. In the last month, how much has pain interfered with the worker's daily activities and functions? Circle number:

0	No interference. Goes to work each day, has a social life outside of work, takes an active part in family life
1	Can work/volunteer, is active eight hours daily, takes part in family life, has limited outside social activities
2	Can work/volunteer for at least six hours daily, has energy to make plans for one evening social activity during the week, is active on weekends.
3	Can work/volunteer for a few hours daily, is active at least five hours daily, does simple activities on weekends
4	Can work/volunteer limited hours, has limited social activities on weekends.
5	Not able to work/volunteer, struggles with home responsibilities and outside activities
6	Does simple chores around the home, has minimal outside activities two days a week
7	Gets dressed in the morning, has minimal activities at home, has contact with friends via phone or email
8	Gets out of bed but doesn't get dressed, stays at home all day
9	Stays in bed at least half the day, has no contact with the outside world
10	Unable to carry out any activities. Stays in bed all day, feels helpless and hopeless about life.

PRACTICE POLICIES

To best meet the needs of all our patients, we would like to remind everyone of the following policies. Thank you.

1. APPOINTMENT CONFIRMATION/CANCELLATION POLICY

As a courtesy, you will receive a COMPUTER call 2 days prior to your appointment to remind you of the date and time. Please follow the computer prompts to confirm. If you would like to cancel, please contact our office at least one business day PRIOR to your appointment.

***Effective November 2008, there will be a patient charge of \$25 for any appointment not cancelled with at least a 1 business day notice.**

2. MEDICATION PRESCRIPTIONS

All medication prescriptions will be given during your scheduled appointment time. These prescriptions will be for the amounts appropriate to control your pain until your next visit and must be utilized as directed by your provider. Early refills are only allowed with authorization by the prescribing physician. Refills requests cannot be given over the phone. You are responsible for your prescriptions. Stolen or lost refills will not be replaced until the date for which they were originally scheduled. We do not prescribe medication for undiagnosed pain.

You must inform us of any prescription-controlled substances you are obtaining through other physicians. Failure to do so may result in discharge from our practice. It is illegal to share prescription drugs and to alter or forge prescriptions, and our practice reserves the right to discharge patients engaging in such activities. Our practice also reserves the right to discharge patients engaging in activities considered "drug-seeking", such as persistent medication use past the period indicated by the physician; repeated visits to emergency rooms with pain complaints; and other activities in this category, at the discretion of your provider.

3. CLINICAL QUESTIONS

If you have questions, would like to leave a patient update or request information you can contact us via the WEB PORTAL. Please visit www.thephysicians.com and select PATIENT PORTAL. However, if the question requires extensive medical decision making, you will need to schedule an appointment.

4. FORMS AND ADDITIONAL REQUESTED SERVICES

There will be a processing fee for completing insurance and disability forms not directly associated to billing your visits. The fee will be determined by the physician, depending on the extent required of the form. This fee also applies to the insurance medication prior approval process, which your insurance carrier does not include in your physician services. We appreciate your understanding with these policies. We unfortunately cannot control the additional work insurance companies are requesting for patients and providers each year that are not included in the medical services provided. We are doing our best to make sure that we remain focused on the services we provide –medical care- to treat our patients with the highest level of care possible.

5. MEDICAL RECORDS

Please note that any requests for medical records copies needs to be in writing. We will fax records directly to your other treating providers, upon this written request, for no fee. Appropriate copying charges will apply for all others, to cover the time and resources required.

6. CONSENT TO USE OF ELECTRONIC COMMUNICATIONS

I consent to communicate with The Physicians Spine and Rehab using the following means of electronic communication: text, email and patient portal. I understand that this request to receive electronic communications will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I understand that I have the right to withdraw my consent to receive/obtain text message communication from The Physicians Spine and Rehab at any time. I agree to notify The Physicians Spine and Rehab if my telephone number or email changes. I understand that I assume any costs incurred related to receipt of text messages. I understand that electronic media and delivery methods such as e-mail and text messaging pose certain risks to the privacy and security of my protected health information. By my signature below, I agree to assume such risks personally and to hold The Physicians Spine and Rehab and agents harmless in the event that my protected health information is breached or compromised because of my directing and authorizing The Physicians Spine and Rehab and agents to transmit or deliver such information electronically. Any questions I had have been answered. I have reviewed and understand all of the risks, conditions, and instructions described in this consent form.

I voluntarily consent to the collection and testing of my urine and or blood samples by The Physicians Spine & Rehabilitation Specialists of Georgia, PC, and The Physicians Lab Services (a CAP accredited, CLIA approved lab) as long as I am a patient of The Physicians. The urine is mine and freshly voided, I certify that this sample has not been adulterated in any manner. I certify the information provided on this form and on the label affixed to the sample container are correct.

Warning: Under Georgia law, there is no liability for an injury or death of an individual entering these premises if such injury or death results from the inherent risks of contracting COVID-19. You are assuming this risk by entering these premises.

I have read and understand the above policies.

Printed Patient Name or Representative

Signature

Date

FINANCIAL POLICY – WE WANT YOU TO BE INFORMED!

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. As part of this commitment, we provide several services as a courtesy to you, the patient, as outlined below:

If you have:	You are responsible for:	As a courtesy to you, our staff will:
An HMO, POS, PPO, or other insurance with which we are contracted	1) Obtaining a referral from your PCP (if applicable) 2) Payment of Co-pays & Deductibles at the time of service	File an insurance claim on your behalf
An HMO, POS, PPO or other insurance with which we are not contracted	If your insurance plan offers “out of network” benefits payment is REQUIRED at time of service based on your “ out of network ” benefits. Many insurance companies base their payment on “ usual and customary ” charges. The patient is responsible for ALL FEES above “ usual and customary. ” (UCR) If your insurance plan does not have “ out of network ” benefits, we will not file these claims. We will provide you the option to pay at the time of service with prompt pay discount.	For POS and PPO , we will file an insurance claim on your behalf. HMO plans do not have out of network benefits and will not cover any charges. We will not file these claims. These patients will be provided the option to pay at the time of service with prompt pay discount.
Medicare without secondary	Payment of deductible and coinsurance at time of service	File an insurance claim on your behalf
Medicare, HMO, POS, PPO, and commercial ins. w/secondary	Payment of deductible and coinsurance at time of service if not covered by secondary insurance	File an insurance claim on your behalf, as well as any claims to your secondary
Prompt Pay Patients (Patients with no insurance, or those who choose NOT to file with insurance)	<u>PAYMENT MUST BE MADE AT TIME OF SERVICE.</u> The discount DOES NOT apply if payment is not made IN FULL at time of service. Patient will be responsible for 100% of ALL charges incurred that day.	Providing a prompt pay discount for paying at time of service. Patient or Provider WILL NOT file charges from that date of service with insurance of any sort.
Workers Compensation	Provide us with the accident date, claim number, attending physician, employer, and adjuster information.	File an insurance claim on your behalf
Accident Related (non Workers’ Compensation)	Payment must be made in full at time of service or filed with your insurance plan (see above responsibilities), if a Lien is not on file. If the accident is related to an automobile accident, we will file with auto insurance. Auto insurance must be provided with claim number and med pay confirmed. If not on a Lien and not related to a work related injury or automobile accident, we will need written acknowledgement confirming this is not work or auto accident related and not being litigated.	File an insurance claim on your behalf with required documentation (i.e. written acknowledgement confirming this is not work or auto accident related and not being litigated.) If an auto accident, will file with auto insurance until Med Pay is exhausted. Once Med Pay has been exhausted, file insurance claim with health insurance including letter from auto insurance stating Med Pay is exhausted.

Patient Initials _____

Billing Process and Notices

We file insurance as a courtesy but this does not release the patient from financial obligation. We will attempt to verify benefits prior to your appointment to determine eligibility, deductibles, coinsurance, and obtain approval. **THIS DOES NOT GUARANTEE REIMBURSEMENT.** The patient remains fully responsible for the entire amount of the bill.

Charges not covered by insurance company, as well as applicable co-payments and deductibles, are patient's responsibility.

Patients are expected to pay for all estimated copay, deductible and co-insurance cost at time of service as required by insurance company. If for some unforeseen reason a patient cannot pay the co-payment, the patient will have the option to reschedule or agree to pay an additional \$10.00 fee that will be added to the account for the collection cost of the co-payment, deductible and/or co-insurance after the date of service.

In order to help keep you informed, you will receive monthly statements or notices about your services with us as long as there is a balance on your account.

If we are filing insurance on your behalf, we will not send these statements to you until we have received payment or other information from your insurance. You may receive an EOB from your carrier, prior to our statements.

You will continue to receive statements monthly, as long as there is a balance. After 90 days of statements, if you have not made payment arrangements, your account balance will be sent to CBA collection agency.

If you are scheduled for a procedure, **PLEASE NOTE THE BILLING FOR THE PHYSICIAN AND FACILITY IS SEPARATE.** The bill from the facility (surgery center or hospital) includes the costs of the procedure room, medical supplies, and medications. The physician bills separately for their services.

Patient signature below authorizes The Physicians Spine & Rehabilitation Specialists to release pertinent medical information to your insurance company when requested, or to facilitate payment of a claim.

I have read and understand the above Financial Policy. I authorize my insurance benefits to be paid directly to The Physicians Spine & Rehabilitation Specialists

PATIENT SIGNATURE

PRINTED NAME

DATE

PRIVACY NOTICE ACKNOWLEDGEMENT

PATIENT NAME: _____ Date of Birth: _____

I acknowledge that I have reviewed a copy of the Privacy Notice for The Physicians Spine & Rehabilitation Specialists

Privacy Notice Revision Date: April 14, 2003

Patient or Personal Representative Signature

Date

Personal Representative's Relation to Patient

THE PHYSICIANS
Spine & Rehabilitation Specialists

OFFICE USE ONLY**DOCUMENTATION OF GOOD FAITH EFFORT**

The patient identified above was provided a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgment of the patient's receipt of the Privacy Notice.

However, acknowledgement has not been obtained because:

Patient refused to sign the Privacy Notice Acknowledgment

Patient was unable to sign because: _____

There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

Other reason, described below: _____

Employee Printed Name

Employee Signature

Date

AUTHORIZATION TO DISCLOSE/PROVIDE INFORMATION

My signature below indicates the authorization to release my medical information, including history, treatment, diagnosis and prognosis and any information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care provided, health related utilization review or quality assurance activities.

By signing below, I hereby consent for this practice to use or disclose information about myself (or another person for whom has the authority to sign) that is protected under federal law, for the sole purpose of treatment, payment and healthcare operations. I understand that I may refuse to sign this form.

My signature below indicates my authorization of any medical information including history, treatment, diagnosis, and prognosis to be released to:

The Physicians Spine & Rehabilitation Specialists
790 Church Street Suite 550, Marietta, Georgia, 30060
Phone: (770) 419-9902, Fax: (770) 419-7457

The Physicians Spine & Rehabilitation Specialists
1060 Red Bud Road, Calhoun Georgia 30701,
Phone: (706) 314-1919, Fax: (706) 629-4904

The Physicians Spine & Rehabilitation Specialists
5730 Glenridge Drive, Suite 100, Sandy Springs, GA 30328
Phone: (404) 816-3000, Fax: (678) 904-5797

The Physicians Spine & Rehabilitation Specialists
18 Riverbend Drive Suite 100, Rome, Georgia, 30161
Phone: (706) 314-1900, Fax: (706) 314-1901

The Physicians Spine & Rehabilitation Specialists
1035 Southcrest Drive Suite 250, Stockbridge, GA 30281
Phone: (678) 275-2200, Fax: (678) 275-2201

The Physicians Spine & Rehabilitation Specialists
3855 Pleasant Hill Road Suite 380, Duluth, GA 30096
Phone: (770) 752-1502, Fax: (770) 999-0850

PATIENT TO COMPLETE: The practice may communicate with the following individuals regarding my condition or course of treatment:

- 1. _____ 2. _____
- 3. _____ 4. _____

You may communicate confidential information to me, including invoices for services, to the home address, home phone and cell phone listed on my patient demographics.

I understand that pursuant to the Health Insurance Portability and Accountability Act (HIPAA) this protected health information is being used by The Physicians Spine & Rehabilitation Specialists for the purpose of providing treatment, and the business operations and billing that go along with this treatment. By signing below, I recognize that the protected health information used or disclosed pursuant to the consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Printed Patient Name/Personal Representative Patient/Representative Signature Patient Date of Birth

Date Personal Representative's Relation to Patient



General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PATIENT RIGHTS & RESPONSIBILITIES

Patient Rights and Responsibilities are posted in the waiting room of the practice and are offered to patients. **Please note that this facility employs various types of licensed health care practitioners, including Medical Doctors (MD), Doctors of Osteopathic Medicine(DO), Registered Nurses (RN), Medical Assistants (MA), and Radiology Technicians (RT). As a patient, you have the right to inquire about a practitioner's license.

My signature below confirms that I have read and understand my rights and responsibilities as a patient.

—
—

Signature of Patient or Representative

Date

Printed Name of Patient or Representative

Date

Signature of Witness

Date

Printed Name of Witness

Employee Job Title



Patient Cancellation/ Reschedule/ No-Show Policy

Office Visits and Surgery Center Procedures

We understand that sometimes life can get in the way of you making your appointment. However, our providers have allotted a specific time for your appointment, and your late cancellation/ reschedule or no-show is not only inconvenient for our staff, but it also disrupts our providers' schedules. There is a high demand for their time and we want to ensure that our providers are able to see everyone. For these reasons, our practice has implemented the following cancellation policy:

Please advise our office of cancellations or requests to reschedule at least 1-business day before your appointment. Any notice given less than one 1-business day in advance may incur a late-cancellation fee of \$25 for an office visit, and \$50 for a procedure block.

**** If an appointment is missed or rescheduled more than 3 times within a month, the patient may no longer be able to be scheduled for continued care***

We respect our patients' time and we expect our patients to be prompt for their appointments. If you are concerned that you may be tardy, please call the front office as soon as possible to advise our staff. Please note that any delays greater than 30 minutes will likely result in your appointment being rescheduled. Arriving late for your appointment may cause delays for our staff and your treating physician, and although we will do our best to accommodate you, unfortunately we cannot allow one person's tardiness to inconvenience the rest of our patients.

We appreciate your understanding of these matters.

Please sign below to acknowledge that you have read and understood the policies stated above.

Patient Name: _____

Patient Signature: _____

Date: _____