Patient Bill of Rights and Responsibilities

Patient Name _____ Patient DOB _____

I have the right to be seen in a timely manner. I will be informed of any unforeseen delay and will have the right to reschedule if the delay is too lengthy.

I understand that if I am unable to keep my scheduled appointment and I fail to give 24 hours' notice, I may be charged a fee for my time reserved.

I understand that if I am a new patient and I fail to cancel/do not show up for my initial (first) appointment in a timely manner, I may not be rescheduled.

I agree to be on time for my appointments. If I arrive late for my appointment, it may need to be rescheduled. If my patient information needs to be updated, I may be asked to arrive 10 minutes early.

I understand that if I do not show up for 3 appointments without calling to cancel 24 hours in advance, I may be discharged from the practice.

I agree to take my medications only as prescribed/directed. If I don't understand the directions, I agree to call the office for clarification. (Please give 24-48 hours' notice for refills.)

I understand that I will be informed of abnormal test results. I agree that if this requires an appointment, I will do so at my earliest convenience.

I understand that if I pay with a check and it is returned for insufficient funds, I agree that I am responsible for all fees incurred.

I understand that there will be a charge for completion of all forms. I agree to pay the fee when the form is dropped off, prior to completion of the form.

I understand that I am ultimately responsible for payment of all services and that Apple Family Medicine is billing the insurance carrier on my behalf.

Private pay patients: Payment is expected in full at the time of service.

Commercially insured patients: Payment of copay is expected at the time of services, per insurance contract.

Medicare patients: If my services are not covered by Medicare, I agree that I am responsible for payment.

If I fail to pay my bill in a satisfactory manner and my account is assigned to collection, I agree to pay all costs of collection including attorney fees.

I agree that this office can only bill a diagnosis documented in my medical record. Asking Apple Family Medicine to change a diagnosis for the purpose of securing payment from my insurance carrier may be asking Apply Family Medicine to commit an act of fraud.

I understand that failure to comply with these rights/responsibilities may result in discharge from the office.

_____ _____

Signature of Patient or Legal Representative Printed Name of Patient or Legal Representative

_____ _____

Witness Date Signed