ULTIMA
MEDICAL & AESTHETICS

A Premier Medical Practice!

OFFICE POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality health care. This policy explains various items including your questions regarding patient and insurance responsibility for services rendered, medication refills and follow up appointments. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request. Please initial on each line indicating that you have read and understood the policies.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. _____

2. **Co-Payments and Deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. _____

3. **Insurance Billing**. We will bill your insurance carrier as a courtesy. However, it is ultimately your responsibility to pay for services received in a timely manner. If for any reason your insurance does not cover a service or does not pay, you are responsible for the balance. _____

4. **Proof of Insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of any pending claims. _____

5. **Claims Submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your benefits and coverage is a contract between you and your insurance company; we are not party to that contract.

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6. **Non-Payment of Co-Pays or Balance Due**. If you do not pay your co-pay or balance due at the time of service, a service fee of $10.00 will be charged for each co-pay or unpaid balance at the time of service. This is in addition to the late fees and service charges added on monthly statements. _____

7. **Coverage Changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. _____

8. **Non-Payment**. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency, and you will be reported to credit bureaus. _____

9. **Non-Covered Services**. Please be aware that some and perhaps all of the services you receive maybe non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. _____

10. **Missed Appointments**. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please give at least 24 hours' notice if you need to reschedule or cancel your appointment. Otherwise you will be charged a No Show fee of $25.00. Please help us to serve you better by keeping your regularly scheduled appointment. _____

11. **Lab Billing:** We send all blood work to specific laboratories for your convenience. Your insurance company is billed directly by the laboratory. If your insurance does not cover a charge it is your responsibility to speak directly with the lab billing department and your insurance company. We are not responsible for laboratory billing. _____

12. **Lab Results**. No abnormal lab results will be discussed over the phone. You will be requested to make a follow up appointment to discuss lab results and changes in medication management as needed. If urgent, you will be asked to come in sooner. _____

13. **Medications.** Please bring all your medications or a list of medications with you. Discuss all refills requests with the doctor during your visit. Medication refill requests outside of your appointment may be denied if your follow-ups are not up to date. _____

14. **Medication Refills**. Please allow 72 hours notice for medication refills. You are responsible for scheduling appointments for medication refills before you run out of medications. _____

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15. **Controlled Substances**. No narcotic pain killers, benzodiazepines or sleep aid medications will be prescribed without an in office physician evaluation. Please make an appointment to be evaluated and treated. _____

16. **Automated Refill Requests**. We kindly ask patients NOT to sign up for automatic refill requests at your pharmacy. Please call the office for refills. We will gladly help you and save a few trees in the process by saving fax paper. Thanks! _____

17. **Medical Forms**. Health/medical forms of any kind will not be filled out without an appointment. Exceptions exist. Please check with the front desk staff about the fee and policy for different types of forms. Please allow 5 business days for all forms to be completed. _____

18. **Medical Records**. There is a charge for copies of medical records and a service fee. At least seven working days are required for preparation and release of medical records after payment is received. _____

Our practice is committed to providing the best treatment to our patients. Help us better serve your needs by scheduling timely follow-up appointments and blood work as recommended by the physician. This will ensure that all your concerns are addressed and you have enough medication refills till your next appointment. Thank you for understanding our office and payment policy. Please let us know if you have any questions or concerns.
Your cooperation in making Ultima Medical & Aesthetics, an efficiently run practice is greatly appreciated.

A photocopy of this agreement shall be considered as valid as the original.

I have read and fully understand the office policy and agree to abide by its guidelines.

_____
(Signature of patient or responsible party)

_____ _____
(Name of patient – Please print) Date