DESCHUTES RHEUMATOLOGY

Deschutes Rheumatology Patient Agreement

I understand and voluntarily agree that I will abide by the following clinic expectations:

_____ I will keep, and be on time for all my scheduled appointments with my provider and/or other members of the treatment team.

_____ I will take my medications as instructed and not change the way I take it without consulting my provider or other members of the treatment team.

_____ If an appointment and/or lab work is required to authorize a medication refill, I will commit to making and keeping my appointment and/or completing required lab work. If I have trouble making or keeping an appointment, I will communicate with the staff and/or my provider.

_____ I will sign a release form to permit my provider, at Deschutes Rheumatology, to communicate to other providers within my care team, if the need arises.

_____ I will inform my provider of all other medications I take, and let them know immediately if I have been prescribed a new medication.

_____ I will treat the staff at Deschutes Rheumatology with respect **AT ALL TIMES**. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment can or will be stopped, and could also result in being discharged from the practice.

NO SHOW POLICY

If you fail to notify us within 24 hours of your scheduled appointment you could be charged a $100.00 cancellation fee. If you have more than 2 no shows you could possibly be discharged from the practice which is determined by your provider.

PAYMENT/CO-PAYS/INSURANCE

We participate with many major health plans and we bill your insurance as a courtesy. **IT IS YOUR RESPONSIBILITY, AS A PATIENT, TO VERIFY THAT DESCHUTES RHEUMATOLOGY HAS YOUR CORRECT INSURANCE INFORMATION AND TO INFORM DESCHUTES RHEUMATOLOGY IF THERE ARE ANY CHANGES WITH YOUR INSURANCE.**

All Co-pays and Patient Balances are due and payable at the time of your visit, unless satisfactory arrangements have been made with our billing office prior to the date of service. On accounts which have established arrangements, the payment is due upon receipt of the monthly statement. To better assist our patients, we accept Cash, Checks, Visa, MasterCard, American Express and Discover.

RETURNED CHECKS

Checks returned from the bank for any reason will be charged an initial **$25.00** fee and **$35.00** thereafter.

I have read and understand the above appointment policy. I have read this policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account.

(SIGNATURE) **(DATE)**