

Patient Responsibility

OFFICE HOURS – Monday – Thursday 8-5 Friday 8-1. Appointments preferred. Same day appointments should be available if you call before 10:00 a.m. on the day you wish to be seen. Our office will attempt to contact you about your appointment one day prior to it. **If you fail to notify us at least 12 hours prior to your scheduled office visit and do not keep your appointment, you will be billed a \$20 no show fee.** Your insurance company will not pay this fee and you will be responsible.

FINANCIAL POLICY – Payment is expected at the time of your office visit. We accept VISA, MasterCard, Discover, American Express, Debit Card, & Cash. Personal checks may be accepted with valid South Carolina Drivers License upon approval. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance. ** If your insurance is not one we participate with then you will be responsible for payment in full at the time of service. If we later receive a check from your insurer, we will refund any overpayment to you. ** If your insurance company is one we participate with you may pay your estimated portion at the time of service. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. ** Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. **There will be a \$30 fee for all returned checks. Balances over 90 days old may be subject to collections.**

SEPARATE BILLING – Certain laboratory services are processed and billed by Laboratory Corporation of America (Lab Corp). Therefore, for all pathology/cytology tests and certain lab tests, you will receive a separate bill for specimens sent to the above referenced laboratory.

DISABILITY / FMLA / LEAVE OF ABSENCE FORMS – There will be a minimum \$20 charge for form completion. This fee must be paid in advance. Our office requires seven to ten business days to complete the forms. Some cases may require an office visit with the doctor.

AFTER HOURS / WEEKEND CALLS – Should you need to speak to a physician after hours call our office at (843) 293-8850 and listen carefully to the recorded message. It will direct you where to call. **If it is a life-threatening emergency, call 911.**

PRESCRIPTION REFILLS – If you need a refill on your prescription(s) please contact us directly. This includes mail order pharmacy refills, or transfers of prescriptions from one pharmacy to another. Please allow 24 hours to process.

RETURN CALLS – All patient calls will be responded to in a timely manner, but some may take 24 hours before you receive a response. If you call by 3:00 P.M., every attempt will be made to have an answer to your question before the end of the day. Please leave a phone number(s) where you can be reached during the day. Return calls are responded to in this manner so that our physicians are not interrupted during that day’s scheduled patient visit.

By my signature, I understand that I am directly responsible to this office for all charges, and that I must provide a valid picture ID, current insurance, and health history information. I also understand that all co-payments co-insurance, and payments for services not covered by insurance are due the date service are rendered. I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Family Medicine of SayeBrook, LLC for any administration and its agents any information needed to determine these benefits payable to related services. I authorize you to release to HCFA and any other carrier and its agent any information needed to file and process my claim.

I authorize the physicians of Family Medicine of SayeBrook, LLC, his/her staff to perform and do hereby consent to such medical treatment as he/she feels necessary, including diagnostic procedures, medical exams, and treatment as he/she feels necessary. I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment, or examination.

I have read and understand the practices policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Patient Signature _____ Date _____

Patient Name Printed _____ Witness _____