

**BLACK MOUNTAIN FAMILY MEDICINE OFFICE POLICY**  
**ACKNOWLEDGEMENT**

By signing this form below, you have acknowledged that you have received and will read/review the office policies form and adhere to the policies as established by this medical practice. **Please do not discard the office policies sheet as it is your reference to the guidelines established by this practice.** This sheet serves as a reference for you and any additional revisions will be distributed to you in the future with additional signatures required for various updates. Thank you.

I, the undersigned patient of Black Mountain Family Medicine, acknowledge that I have received the Office Policies sheet as established by the practice. I further agree that I will review and keep the office policies form in my possession for further reference as to the policies of Black Mountain Family Medicine as they apply to me as a patient of the practice.

**DATE**

**PATIENT SIGNATURE**

**September 2005 Policy**

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## **BLACK MOUNTAIN FAMILY MEDICINE OFFICE POLICIES**

### **OFFICE POLICY ON PAYMENT**

It is our policy to require payment of all office charges and co-payments **at the time of service**. All accounts over 60 days will be charged a monthly interest fee of \$2.00 minimum. In the event any balance due is not paid as agreed, the undersigned agrees to pay all costs charged by the collection company, including any reasonable attorney fees.

### **INSURANCE POLICY**

We will submit your charges to your insurance company as we participate with most insurances. However, **it is your responsibility** to determine whether Dr. Bickle (Black Mountain Family Medicine) participates with and accepts assignment (payment) from your carrier. You must provide our office with the correct name, billing address, policy number, and place of employment as well as any other important information necessary in order to bill your insurance carrier for your charges. Please understand that we cannot become involved in prolonged insurance negotiations and that you are responsible for all deductibles and charges not covered by your insurance. **It is your health insurance, please understand all that you can about your coverage and referral requirements.**

Also, **you must present your insurance card to the receptionist prior to each office visit**. This is due to the numerous changes in insurance cards that we often encounter. **FAILURE TO UPDATE YOUR INSURANCE INFORMATION DURING EACH OFFICE VISIT WILL RESULT IN REJECTION OF YOUR CLAIM FROM THE INSURANCE COMPANY AND, THE TOTAL MEDICAL CHARGES WILL BE YOUR RESPONSIBILITY**. Black Mountain Family Medicine will not re-submit an insurance claim to your carrier for failure to update your insurance information at the time of the office visit.

**By signing acknowledgement of receipt of this form you authorize the release of any medical information necessary in order to process any claim.** Either you or your insurance company may revoke this authorization at any time in writing.

### **REFERRALS**

It may be necessary from time to time to refer you to a specialist or other provider of care. Every attempt will be made to find a provider who also participates with your insurance. Our office will obtain any necessary authorization and forward such to the specialist. We ask in return that you schedule your own appointment with that specialist. Also, we ask that you allow us one (1) week to process non-urgent referrals.

**Please call our referral line at 480-595-8923** in order to leave your referral request information. We ask that you leave **your name, insurance info, specialist's name, phone number, and fax number** in order to expedite your referral.

By signing acknowledgement or receipt of this form, I authorize the release of any information necessary to process my referral request to the specialist, including any medical records deemed necessary for the specialists' review.

### **PRESCRIPTION REFILLS**

It is our policy that you have your pharmacy fax all prescription refill requests to us at **480-595-8910** unless other arrangements have been made (mail order). It is your responsibility to follow up with your pharmacy to ascertain the status of the request. After hours and weekend prescription refill requests will not be addressed until the next business day. Any urgent/emergent requests should be phoned in. **Refills for controlled substances (narcotic pain killers) will not be phoned in on the weekends and request for such may result in dismissal from the practice.**

### **LAB**

We are not a lab drawing station and we draw blood only as a courtesy to our patients. Dr. Bickle (Black Mountain Family Medicine) is **not responsible** for any lab charges that are not covered for any reason. It is your responsibility to know what lab your blood specimen must be sent to and you must inform us as **we are held harmless** from any fees billed to the patient by the lab for any reason whatsoever.

### **OFFICE VISIT "NO SHOWS" AND CANCELLATIONS**

As a common courtesy to other patients whom may be waiting to schedule an appointment or are turned away until the next available appointment, we ask that if you are unable to make your scheduled appointment that you give us at least **24 HOURS** notice to cancel your appointment. This allows us to accommodate other patients who would like to schedule an appointment or whose needs may be more urgent. It is your responsibility to remember the time and date of your scheduled appointment. **Patients who fail to show up for an appointment (no show) will be charged a \$35 fee which will be charged directly to the patient. Three (3) or more "no show" missed appointments may result in dismissal from the practice.**

### **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

By signing the acknowledgement of receipt of this form, I authorize the Provider of care to release any medical information including diagnoses, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, legal, insurance billing/payment, and at times when the provider of my care deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the information obtained by this authorization to

any other person or organization without a further authorization signed by me for release of the information.

### **PHYSICAL EXAM COVERAGE**

As part of quality preventative care, Black Mountain Family Medicine recommends that **every patient** undergo a routine annual physical examination. However, **some insurance carriers do not provide coverage for routine physical examinations**. We ask that prior to your physical examination that **you verify that your insurance does provide a benefit** for routine annual physical exams. Other arrangements may be made if your insurance does not provide this benefit. Failure to verify that your insurance does not cover routine physical exams **will result in rejections of your claim and you will be responsible for all charges incurred**.

### **CHANGE OF ADDRESS**

**It is your responsibility to notify us of any change of address immediately.** Often this goes unseen by most patients and as a result many patient accounts become past due and are **sent to collections** for a simple matter that can be resolved in a manner of minutes. We kindly ask that you be courteous and considerate by notifying us of your change of address. This could save you and us from headaches in the future.

### **LAB RESULTS/MDVIP CONNECT**

Please note that all test results that you have ordered through our office will be left for you either on the **“MDVIP CONNECT” PATIENT PORTAL OR DIRECTLY CALLED TO YOU**. Our preference is the **MDVIP CONNECT PATIENT PORTAL (so if you have not registered by now, please do so or, ask us how)**. These tests include: bloodwork, x-rays, pap smears, skin tissue biopsies, plus any and all other testing that is ordered through our office. **NEVER ASSUME THAT YOUR TEST RESULTS ARE NORMAL IF YOU HAVE NOT HEARD FROM US**. You should receive notice on **all test results** from the “MDVIP CONNECT” system or direct call from us within **10-14 days after** you have any testing done through our office.

**IMPORTANT: If you do not hear from us regarding your test results, DO NOT ASSUME THEY ARE NORMAL**. We ask that you call us after 14 days so that we can ascertain as to why your results are not back or, why they were not placed on the MDVIP CONNECT PORTAL OR DIRECTLY CALLED TO YOU.

### **PHONE NUMBERS**

We ask that you please leave us **at least 2 phone numbers** in order to contact you as well as the

phone number(s) of your emergency contact(s). We ask that **one of your phone numbers be your cell phone** if applicable. This helps us get a hold of you if needed in any urgent matter. We also ask that you please update us with any change of your phone numbers so that we may update our records accordingly.

#### **ON-CALL PHYSICIANS/COVERAGE**

Please note that a physician is “on-call” 24/7 for **medical issues that cannot wait until routine office hours. The on-call physician is not there to answer general medical questions or routine prescription refills that can be handled during normal office hours on weekdays. In the case of any medical emergency, you should ALWAYS call 911.**