Office Policies

Insurance Authorization

_____(Initial) I hereby authorize Chino Hills Family Medical Group to release to my insurance company, third party insurance, or their medical review companies, all medical information necessary to secure payment of medical services. I hereby authorize payment of all medical/surgical benefits, to be paid directly to Chino Hills Family Medical Group. **I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance, such as copayments, deductibles, and coinsurance.**

Check In/Appointment Times

_____(Initial) I understand that it is my responsibility to arrive on-time for my appointment. I understand that if I arrive 10 minutes after my appointment time, I will be rescheduled as accommodating late patients is a leading reason for extended wait times for the patients.

Payment

_____(Initial) I understand that copays and cash services are expected to be paid at the time that the service is rendered. Balances not paid by my insurance company will be expected upon determination of covered benefits. Payments not paid within 90 days will be subject to collection for an additional fee at my responsibility.

Identification

_____(Initial) I understand that in order to be seen in the office, I must provide a valid form of photo identification. I acknowledge that this policy is an effort of Chino Hills Family Medical Group to protect me and all patients from identity theft and that no exceptions will be made. I accept that it is at the discretion of the management to determine if any provided form of identification is "valid".

No Show Policy

_____(Initial) I understand that a missed appointment leaves an empty slot that could have been used for a patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients. If I am not able to keep my scheduled appointment, I must notify Chino Hills Family Medical Group at least 4 hours in advance, so the time might be available to someone else. A missed appointment, or "no show', occurs when any patient fails to give notice that the appointment cannot be kept. I understand that if I miss appointments without giving the required notice I could be subject to a $25 missed appointment fee.

Prescriptions

_____(Initial) I understand that all prescription refills should be requested through my pharmacy during business hours when my medical record is available to my healthcare provider. I understand that I must allow 2-3 business days for a response and that it is my responsibility not to wait until I am completely out of medication before requesting a refill. I acknowledge that antibiotics and controlled substances (narcotic pain medications, anxiolytic sedatives, ADD/ADHD medications, etc) require an office visit with examination to be refilled, and that providing these medications without a visit is at the discretion of my healthcare provider on a case by case basis. **I acknowledge that refills for pain medications will NOT be given after hours, on weekends or holidays.**

Form Fees

_____(Initial) I understand that there are no fees charged for routine completion of forms. I further acknowledge that all forms require up to 10 days to complete. I understand that it is my responsibility to complete my portion of any forms prior to dropping the forms off and that failing to complete or sign the forms could result in a delay in their completion. I further acknowledge that the 10 days does not begin until I have completed my portion of any forms and dropped them off. I understand that if I require the forms to be completed immediately, there will be a $25 fee for expedited service as the provider will have to stop all other work in progress to complete them.

We know that you have many choices for your medical care and appreciate you entrusting us to provide your medical services. We reserve the right to refuse service to anyone.

I have read this information and understand and agree to the policies of Chino Hills Family Medical Group.

_____ _____ _____

Patient/Parent/Guardian Signature Patient Name Date

Revised 09/19/17