POLICIES

Our Commitment to You

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.

General Information

- Our office hours are very limited. It is very important that you keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 24 hours** prior to your schedule appointment date.
- We may charge a **NO SHOW FEE/LATE CANCELLATION** if your appointment is not kept or cancelled 24 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.

Medication Policy

- It is important to your health that you follow directions carefully on all medications that we prescribe.
- In addition, we must be informed of **ALL** other medications, prescription or over-the-counter.
- We will **NOT** refill **ANY** medication without coming in for an appointment.
- **When a prescription is written, it is expected that the patient return to the office for a follow-up visit prior to continuing that medication. The number of refills written is for that exact purpose and is practicing good medicine.**

EDUCATION NARCOTIC ALERT: If you are prescribed a narcotic you will be educated regarding medication side effects and risks. You will also be educated on abuse, addiction, respiratory depression and if overdose, death to the patient. Medication is able to control pain and improve activities of daily living. Patient was educated regarding keeping medication in a safe place, not to use these medications while driving and avoid alcohol. Patient understands and agrees upon it.

Financial Policy

- We expect that you have an understanding of your responsibilities under your insurance contract with respect to referral and preauthorization requirements as well as your deductible, co-pay, and coverage limits.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.
- If you have insurance coverage with one of the plans with which we participate, we will bill your insurance company along the guidelines of our contract. However, we require that **all co-pays or deductibles be paid at the time of service.**
- Returned checks will be subject to **an additional $25 service fee.**
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- While filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered.
- You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 24 hours in advance**, our policy is to charge a **NO SHOW FEE** for missed office appointments.
- **Missed appointments for procedures is a fee of $100.**

Forms Requiring Physician's Signature

- Form fee is $25.00 for initial and $15.00 for each subsequent.
- Payment is **required** before completed forms are released.
- We require **5-10 business days** upon receipt before completion of any form, **NO EXCEPTIONS.**
  ******Keep in mind it is not our responsibility to obtain forms for you******

I HAVE READ the office policies which I **UNDERSTAND** and **AGREE**. I also **GUARENTEE** payment of all charges incurred from my account. I hereby assign benefits to **MARTIN J SCOTT** for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

______________________	______________________	______________
Patient Name	Signature	Date

______________________	______________________	______________
Witness Name	Signature	Date

WC

M.J. Scott D.O. & Associates, PA

Last Name: ______________________ First Name: ______________________ SEX: M F
If patient is a minor, name of parent or guardian accompanying patient: ______________________
Relationship to patient: ____________________ Phone # (if different): ______________________
Address: ____
City: ______________________ State: ________________ Zip Code: ____________________
Home #: ______________ 2nd Phone: ________________ Email: ______________________
Date of Birth: __________ SS#: ______________ married single divorced widowed (circle one)
Referred by: ______________________ Phone: ________________ Location: ____________
Family Doctor: ______________________ Phone: ________________ Location: ____________
Date of accident: (If applicable): ______________ **Type of accident:** ______________
Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at the time.

____

Primary Insurance Name: ____________________________ Auto Health WC (circle one)
Phone #: ____________________ Adj.: ____________________ Ext.: ______________
Claim or ID #: ____________________________________ Group #: ______________
Subscriber: ____________________________________ Relationship: ______________
Subscriber Date of Birth: ______________ Subscriber Social Security #: ______________
Secondary Insurance Name: ____________________________ Auto Health WC (circle one)
Phone #: ____________________ Adj.: ____________________ Ext.: ______________
Claim or ID #: ____________________________________ Group #: ______________
Subscriber: ______________________________ Relationship: ____________________
Subscriber Date of Birth: ______________ Subscriber Social Security #: ______________
Attorney Name: ______________________________ Firm: ______________________
Location: ________________________________ Phone: ______________________
Employer Name : ______________________________ Phone: ______________________
Emergency Contact: ______________________________ **Phone:** ______________________
Are we authorized to release your medical information to the listed emergency contact? Yes or No (circle)

ACKNOWLEDGEMENT AND UNDERSTANDING

Medical Release – I hereby request and authorize Martin J Scott D.O., to disclose, make available and furnish to:
Company Name: ______________________________
Or his/her authorized representatives all information, records, xrays, reports or copies related to my examination, consultation or treatment and do permit him/her to inspect and make copies or abstracts thereof. I release the doctors, therapists, agents, employee's and any personnel acting on behalf of this office from any and all liability whatsoever pertaining to any use of these records. A photocopy of this form will be valid as the original form

Patient Signature: ______________________________ Date: ______________

Records Release – I hereby authorize the release of my records/x-rays/reports or copies of such and request that they be transferred or made available to Martin J. Scott, D.O.

Patient Signature: ______________________________ Date: ______________

Consent to Treatment of Minor – I hereby authorize Martin J. Scott, D.O., to render healthcare to my son/daughter as deemed necessary by the physician.

Patient Signature: ______________________________ Date: ______________

Authorization for Release of Information

Name of Patient______________________________ Date of Birth ____________

Martin J Scott is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
° Voice Mail	° Results of lab tests/x-rays Other: ____________________ __________________________
° Spouse (provide name & phone number) ________________________ ________________________	° Financial ° Medical as follows: ____________ ________________________
° Parent (provide name & phone number) ________________________ ________________________	° Financial ° Medical as follows: ____________ ________________________
° Other (provide name & phone number) ________________________ ________________________	° Financial ° Medical as follows: ____________ ________________________

______________________________ _______________

Signature of Patient or Personal Representative Date

______________________________ _______________

Signature of Witness Date