Dunkirk Family Practice
2025 Chaneyville Road, Suite 200, Owings, MD 20736 | Phone: 410-286-3865 | Fax: 410-286-8085 | www.DunkirkFamilyPractice.com

GUIDELINES AND PATIENT FINANCIAL POLICIES
REVISED AS OF 04/201

Initials	Item #	Policy
	1.	**Emergencies:** Our providers will make every effort to receive your calls and respond promptly in an emergency If you do not receive an immediate response, you will call 911 receive paramedic intervention and seek the nearest emergency room.
	2.	**Prescription Refills:** It is our policy that you should be responsible to know when your medication must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. For weekend, walk-in, after hours, or phone call refill requests, please allow 72 hours for the physician to refill your request.
	3.	**Information:** You agree to provide your correct name, current and correct address, cellular or other phone number, e-mail address insurance information Social Security number, driver's license or picture identification at the time of registration or as requested by the practice at any time.
	4.	**Financial Responsibility:** By the initial and the signature signed on the financial policy, you accept financial responsibility for ALL charges for services rendered to you if a minor or under guardianship, the parent or guardian accompanying the patient assumes this liability.
	5.	**Payment Methods:** We accept cash, check, and several major credit cards. Reception staff may be contacted regarding credit cards accepted. Active participation with the insurance companies is the responsibility of the patient to obtain BEFORE time of appointment.
	6.	**Appointments:** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian to be seen *unless* special arrangements have been made with the office, which includes a signed written note from a parent or guardian. We require a minimum of 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A fee of $35 will be charged for non-cancelled and missed appointments. A pattern of non-cancelled/missed appointments may result in the discharge from the practice.
	7.	**Well Visits (Two-in-One Visit):** At the discretion of your care provider, you may be responsible for a co-payment after your visit if there are extra concerns that are not covered during our routine preventative care visit.
	8.	**Form Fees:** Our practice charges for additional paperwork outside of the medical records. The following fees apply are subject to change without notice: (a) single page forms- $25; (b) multi-page forms- $35. Additional forms may apply at the discretion of the practice and upon notification to you.
	9.	**Medical Records:** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. The practice charges a fee for a copy of the record according to the fees provided by Maryland State law.
	10.	**Insurance copayments, deductibles, and coinsurance:** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, and coinsurance, or non-covered services are to be paid in a timely fashion according to office policies. If you are unable to pay your copayment at time of service, an extra processing fee of $10.50 will be added to the visit. If requested, and as a condition of the service you agree to sign an "insurance waiver" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

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	11.	**Usual and Customary:** Some insurance plans may indicate that our fees are above "usual and customary". As a result, your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of terms. As such, unless we have specifically contracted with the carrier it is expected that you will be liable for our full fees.
	12.	**Slow Insurance Response:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.
	13.	**Accident:** Although our office is happy to treat your medical conditions, if the cause is related to an auto accident, you will be required to pay the full fee of $180 at the time of your visit.
	14.	**Statement Policy:** Our office sends patient statements each month. Payments are due upon receipt of the statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees.
	15.	**Collection and Bank Fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such collection expense, legal fees and court costs. In addition banks charge for checks that do no clear cannot be cashed. You agree to be liable for all such fees with a minimum charge of $35.
	16.	**Patient Discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your physician.
	17.	**Insurance Claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for the claim from our office to your directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I HAVE READ AND UNDERSTAND ALL THE TERMS OF THIS POLICY AND MY INITIALS AND MY SIGNATURE BELOW ATTECT THAT I FULLY UNDERSTAND EACH ITEM AND AGREE TO THE TERMS ABOVE.

Signature_____Date_____

Patient Name_____DOB_____

Witness_____Date_____

Printed Name_____Date_____