Lancaster Medical
Your Life. Our Specialty

4893 Transit Road | Depew, NY | 716-608-7040
Adult & Family Medicine

OFFICE POLICY (Please Read Carefully & Initial on Line after Each Paragraph & *Bring to Appointment*)

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. We participate with most insurances. It is **your responsibility** as the insured to know if our office participates with your insurance company and policy.

Healthcare as a Partnership _____
Lancaster Medical takes a team approach to your Healthcare. Lancaster Medical works with you to ensure that you are able to make informed decisions. By being a patient at Lancaster Medical, you consent to adhere to the medical policies and recommendations by Lancaster Medical, including adherence to applicable National Healthcare Guidelines. You understand that your healthcare is your personal responsibility and that Lancaster Medical may be forced to sever the relationship if we feel that you are not taking this responsibility seriously. _____

Assignment of Benefits
I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/ medical plan, to issue payment check(s) directly to Lancaster Medical for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. _____

Authorization to Release Information
I hereby authorize Lancaster Medical to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Lancaster Medical on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

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Missed Appointments
The patient is required to notify our office **at least 24 hours in advance of an appointment they wish to cancel or re-schedule or it is considered a NO-SHOW**. If the patient NO SHOWS for (1) a follow up appointment the patient will be **billed a $50.00 fee** - a Physical or Medical Clearance appointment will be billed a $75.00 NO SHOW fee. A subsequent NO SHOW appointment in 12 months will be **billed $75.00**. A patient will be reviewed for release from our practice for failing to show for appointments.

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Communication from Lancaster Medical
You consent for Lancaster Medical to contact you via Phone (Cell, Work & Home), Portal and Text messaging including leaving messages regarding your healthcare. I acknowledge that the Lancaster Medical Portal is for NON-Emergency use only and I will call 911 for an emergency.

Continue onto next page….

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NON-Payment

If your account is 120 days or more over due, you will receive a letter allowing you one last opportunity to pay your bill in full within 10 days. If we do not receive payment you may be discharged from Lancaster Medical for non-payment and your account will be sent to a collection agency. If your account is sent to a collection agency a charge of up to 50.00 may be added to your account to cover their services. Please be advised that you are the patient and ultimately responsible for any charges with Lancaster Medical. Unpaid balances will be reported on your credit report.

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Co-Payments, Co-Insurances and Deductibles and Proof of Insurance

We require a copy of your insurance card and your license, along with your copay or deductible at the time of service. As of August 1, 2009 the Federal Trade Commission passed the law that all Health Care Providers receive a copy of photo identification from all patients who will be using their Health Insurance to pay for their examination, in an effort to cut down on insurance fraud. To remain compliant with this law, Lancaster Medical, has asked patients for their driver license so we could scan it into their charts. By law, a photo ID must be attached to your chart. Refusal to do so will result in us asking to see your license at every appointment. Any co-insurance or deductible will be billed directly to you after your insurance has processed your claim for services rendered. **These balances are expected to be paid in full with-in 30 days.**

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Returned Checks

If you pay any balance with a check that is returned to the office for any reason, we reserve the right to charge your bank fees of, at a minimum, $40.00 and will only accept CASH or CREDIT of future visits.

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Payment Due at Time of Appointment

Insurance co-payments are to be made at **EACH** visit. Failure to do so will result in an additional $5.00 surcharge. This **includes a $75.00 deposit (approximately - different insurances have a different deposit amount) for high deductible plans** each visit until your deductible is met. Our practice accepts cash, personal check, American Express, Discover, Mastercard and Visa. There is a service charge for returned checks (see above statement).

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Paperwork Fees

Certain forms are subject to a $20.00 fee for processing. These forms include FMLA paperwork and disability forms. The fee for other miscellaneous forms is up to the discretion of the physician and administrative staff.

Non-Covered Services

Please be aware that some and perhaps all of the services you may receive may not be covered by your insurance. You are responsible for these charges. If the patient is a minor (under 18), it is agreed that you will accept financial responsibility of these charges regardless of ownership of insurance coverage.

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Worker's Compensation & No Fault

Our office provides Worker's Compensation & No Fault visits as a courtesy to patients who are established and in good standing with Lancaster Medical. These visits are in ADDITION to, not in lieu of your regular insurance visits.

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Change of insurance OR address OR telephone OR name

You are **responsible** to notify the office if your insurance, address, telephone, name changes so we can bill the appropriate insurance carrier in a timely manner. If you do not notify us of applicable changes you will be responsible for all of the incurred charges.

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By signing below, I acknowledge that I have read and understand ALL of the above statements listed in

_____ _____ _____

Patient/Responsible Party Signature Print Patient Name Date

_____ _____

Witness Date