

Patricia Roy, DO, PC



THE PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

1. I have the right to be seen in a timely manner. I will be informed of any unforeseen delay and have the right to reschedule if the delay is too lengthy.
2. I agree to be on time for my appointments. If my patient information needs updating, I will arrive 10 minutes early. I may be asked to re-schedule if I am late in arriving.
3. I agree to take prescribed medication only as directed. If I don't understand the directions, I will call the office for clarification. (Please give 24-hour notice for refills)
4. I will be informed of any abnormal test results. (This may require an appointment)
5. I will pay my co-payment, if I have a co-payment, at the time of appointment. If I fail to do so, and you bill me, I agree to a \$5.00 rebilling charge for each month not paid. Co-pays are due at the time of my appointment per my insurance contract.
6. I will make every effort to understand the benefits of my insurance plan even to the extent of calling the benefit coordinator at my place of employment or the insurance carrier. I will always get the name of the person quoting me the benefits. (Date and time are a good idea too.)
7. I will cooperate with the office to assure prompt payment for the services I receive, including those services not covered by the insurance company.
8. I agree that I am ultimately responsible for payment of services I receive and the office is billing the insurance carrier on my behalf.
9. I agree to pay a \$25.00 charge for any check that is returned by my bank for any reason.
10. If I fail to pay my bill in a satisfactory manner and the account is assigned to collection, I agree to pay all costs of collection including reasonable attorney fees.
11. I agree that this office can only bill a diagnosis documented in my medical record. To ask you to change a diagnosis for the purpose of securing payment from my insurance carrier may be asking you to commit an act of fraud.

Signature of Patient or Responsible Party

Printed Name of Patient or Responsible Party

Witness

Date Signed