

Health Care Agreement

We would like to welcome you and thank you for choosing our office. Our business hours are Monday through Thursday 8:00 am to 5:00 pm and Friday 8:00 am to 4:00 pm. We close for lunch every day between 12:00 pm and 1:30 pm.

Returning Telephone Calls

Occasionally all incoming lines are busy. Please feel free to leave a message and we will return your call by the end of the business day.

Medication Refills

Please allow **24-48** business hours for medication refills. We ask that you call your pharmacy and have them fax a request to our office for the medication(s) you wish to have refilled. If you use a mail order pharmacy, please allow enough time for delivery.

Change of Information

Please inform the front office if there has been a change in your name, address, telephone number or insurance plan.

Payment

Patients are responsible for their medical bills. We will help you by billing your medical insurance, but the co-payments are due at the time medical services are rendered. Our office accepts checks, cash and money orders. If you should have questions regarding your medical coverage or payments, please feel free to speak to our office staff. There will be a nominal charge for additional paperwork such as Disability Forms that are not covered by insurance companies.

Health Care Agreement

Health care requires that the patient and the physician/health care team work together. I understand that if I do not fulfill my part of the agreement, the physician will be less effective in treating me, and may have to stop treating me altogether. **Please read this agreement carefully.**

- 1. I understand that my office appointment is time blocked off for me, and I will call 24 hours or earlier in advance if I am unable to attend my appointment.**
- 2. I understand that I will receive reminder telephone calls the business day before my appointment.**
- 3. I agree to arrive on time for my scheduled appointments. If I am more than 15 minutes late I may not be seen that day and need to reschedule.**
- 4. I understand that if I do not show up for scheduled appointments twice without informing the office beforehand I may not be given future appointments.**
- 5. I understand that after hours calls will be taken 24 hours a day, 7 days a week for emergent medical problems. I may be referred to the hospital emergency department if my problem requires tests, or is serious enough to require hospitalization.**
- 6. I understand that in the event of a life threatening emergency I am to call 911 immediately.**
- 7. I understand and agree to the medication policy.**
- 8. I agree to treat the physicians and staff with courtesy.**

By signing below, I have read and understand the office expectations and agree to follow them. I understand that if I cannot live by the agreement, my care with the clinic may be ended.

Patient Name (Please Print)

Signature

Date

For additional practice information, please visit our website: www.drcarlton.org