MEDICAL ASSOCIATES OF SOUTHWEST VIRGINIA

STATEMENT OF OFFICE POLICIES AND PROCEDURES

Please read this form in its entirety.

Your signature below indicates your agreement and acceptance of these policies. Should you have questions regarding this form, please ask a member of our office staff.

Medical Associates of Southwest Virginia and its staff strive to provide the highest quality care and service to each patient. In order to achieve this, we need your assistance in the following:

1. If I am more than fifteen (15) minutes late for an appointment, I realize it may be necessary to reschedule my appointment so other patients will not have to wait.

2. If I fail to give a 24 hour notice when cancelling an appointment, I realize I will be charged a $25.00 cancellation fee.

3. If I have a returned check, I realize I will be responsible for paying a service charge of $25.00.

4. If I do not have health insurance, I realize I am responsible for paying my bill in its entirety on the day of service, unless prior arrangements have been made. If I do have health insurance, I realize I am responsible for paying my copayment in its entirety on the day of service. I further understand that my insurance provider and Medical Associates of Southwest Virginia file my insurance claim as a courtesy to me and not my insurance company. If payment is not received from the insurance company within 60 days of the date of service, I will be responsible for the full amount immediately.

5. If your insurance requires a referral, it is the responsibility of the patient to make sure this is in place prior to treatment being rendered.

6. Your social security number and date of birth are necessary to submit insurance claims for the purpose of receiving payment from your insurance company. The only other time this information is used is for the purpose of collecting any outstanding balance you may have. Medical Associates of Southwest Virginia and its staff take pride in safeguarding this private information. Your personal information is held in the strictest of confidence and at no time, other than what is indicated in this section, will it be used.

I have read, understood and agree to the above policy and procedures.

_____ _____

Signature of Patient or Patient's Representative Date

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Printed Name