PL Physicians, Inc- New Patient Registration

Patient Information

Name (last, first ,MI)	Social Security Number	Age	Birthdate	Sex	Home Phone
Mailing Address	City	State	Zip code	Marital status	Cell Phone: _____ Email: _____
Employer name and address	City	State	Zip Code	Race	Work Phone

Mothers Information

Mother's First Name:	Mother's Last Name:	Mother's Maiden Name:

Responsible Party Information- Required for All Children

Name (Last, First, MI)	Social security number	Age	Birth date	Sex	Home phone
Mailing Address	City	State	Zip code	Marital status	Cell Phone
Employer and Address	City	State	Zip Code	Race	Work Phone

Insurance Information (please fill out even if you have provided your card)

Primary Insurance co	Subscriber's full name/birthdate/SSN	Relationship	Policy number/Group number
Secondary Insurance Co	Subscriber's full name/birthdate/SSN	Relationship	Policy number/Group number
Tertiary Insurance Co	Subscriber's full name/birthdate/SSN	Relationship	Policy number/Group number

Pharmacy Information

Pharmacy name you use most often	Address	Phone number	Fax number

Emergency Contact Information

Contact Name	Relationship	Home Phone	Cell Phone

PATIENT RELEASE: I certify the information that I have provided is correct. I authorize the release of medical information necessary to process Insurance Claims to Insurance companies or their agencies (Including Medicare) for purposes of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

PAYMENT RESPONSIBILITY: In the event of Non Payment, I agree to bear the cost of collection and/or court costs and reasonable legal fees, should this be required. I understand that copays AND unpaid balances are required at the time of the visit. I permit a copy of this release to be used in place of the original.

Signature: _____ **Date:** _____

PL Physicians, Inc.
4552 Empire Ct.
Fredericksburg, VA 22408

Phone: (540) 361-4779
Fax: (540) 604-9893

Authorization for Release of Medical Information

Patient's Name:_____ Date of Birth:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Date of Request:_____ Date Needed By:_____

I authorize PL Physicians, Inc. to: (check one) ◯ **RELEASE** information to: ◯ **OBTAIN** information from:

Name of Provider or Facility:_____
Address:_____
City/State/Zip Code:_____
Phone #/ Fax #:_____

Purpose for this request (check one): ◯ Healthcare ◯ Insurance Coverage ◯ Personal
◯ Transfer of Care **(reason):**_____ ◯ Other:_____

Type of records requested (check one): ◯ Shot Record ◯ Copy of the entire medical record, as allowed by law
◯ All medical records related to a specific illness or injury: **(Please specify illness or injury and dates of treatment)**
_____
◯ Treatment Summary **(includes history/physical, laboratory test & x-ray reports, operative reports, pathology)**
◯ Specific information **(please check all that apply):** ◯ Procedure Report ◯ History/Physical ◯ Physical Therapy ◯ Laboratory
◯ Test Results ◯ X-Ray Reports ◯ Other:_____

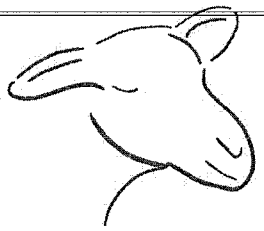
Authorization valid for (check one):
◯ This request only.
◯ One year from the date of this authorization **OR (insert date):**_____. This authorization applies to the records of the treatment received on or prior to the date of this authorization.
◯ This request **and** for medical records of any **future** treatment of the type described above until **(insert date):**_____

I understand that:	**I hereby:**
• My right to healthcare treatment is not conditioned on this authorization. • I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization. • If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed. • Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization. • VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche.	Authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release PL Physicians, Inc. from, and covenant not to sue PL Physicians, Inc. for any claim that I have or may have in the future for release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits. I may request to inspect or copy information used disclosed under this authorization. I understand that I may revoke this consent to release information at anytime except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event, or condition describes as:

NOTE: Medical records are faxed in cases of medical necessity only.

Relationship to patient:_____

Signature:_____ **Date:**_____



PL Physicians, Inc. -Parental Consent

I, _____hereby authorize PL Physicians, Inc. and their representatives to release any and all information pertaining to my Child _____ Date of birth_____ appointment, results, procedures, billing, and or accounting information to the following person(s).

☐ Mother: _____
(Please PRINT name clearly)

☐ Father: _____
(Please PRINT name clearly)

☐ Other: _____ _____
(Please PRINT name clearly) (Relationship to patient)

☐ Other: _____ _____
(Please PRINT name clearly) (Relationship to patient)

I further authorize that the provider and their representative(s) to release results of medical exams in one or more of the following ways:

You may call at this number: _____

Leave a voice mail at this number: _____

I understand that PL Physicians, Inc. will release any information to those persons who I have determined may receive this information without separate consent. I also understand that this relates to all medical and billing/accounting information. **THIS WILL BE ACTIVELY ENFORCED**. If I wish to change status of this form, I will do so in writing.

_____ _____
Parent/Guardian Signature Date

_____
Relationship to patient

PL Physicians, Inc. Assignment of Benefits

&

Release of information Authorization

1. I authorize PL Physicians, Inc. to apply for benefits on my behalf for covered services rendered.

2. I certify that the information I have reported in regard to my insurance coverage is correct.

3. I authorize payment of all medical insurance benefits which are payable under the terms of the insurance policies covering (name of patient) _____ to be paid directly to PL Physicians, Inc. for services rendered. I further authorize the release of any information needed for processing any insurance claims. A copy of this assignment of benefits and release of information authorization may be used in place of the original.

4. This authorization may be revoked in writing my either me or my insurance company at any time.

_____ _____

Signature: **Date:**

Payment Responsibility

1. I understand that co-pays are required at the time of the visit. I further understand that I am responsible for any balance not paid by insurance.

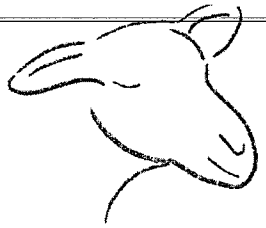
2. I further agree, in the event of non-payment, to bear the cost of collections, and/or court costs and reasonable legal fees should this be required.

_____ _____

Signature: **Date:**

_____

Printed Name:



PL. Physicians, Inc.-Financial Policy

PLEASE INITIAL BESIDE EACH STATEMENT TO ACKNOWLEDGE THAT YOU HAVE READ IT.

Insurance Information: It is your responsibility to understand that various aspects of your insurance policy: for example, whether or not you have a co-pay (and how much it is) or whether you need a referral to see a specialist. _____

Deductible: The amount you must pay out of pocket each year before your insurance will pay for any service. _____

Co-pay: The amount you must pay before each visit to the doctor. This amount is determined by which insurance plan you/your employer have chosen. _____

Our office or one of our covering doctors is available on Saturday mornings for urgent visits. There will be an additional $25 dollar after hour's fee for all Saturday visits. _____

Co-Insurance: The percentage of the billed services that your insurance plan holds you responsible for. For example, if the insurance pays 80%, then you will be responsible for the remaining 20%. _____

Insurance cards: We will need to copy the patient's insurance card at the first visit (front and back). You may be asked to present your insurance card at each subsequent visit. _____

If you have secondary insurance, you will be required to provide the office with a copy of the card (front and back). _____

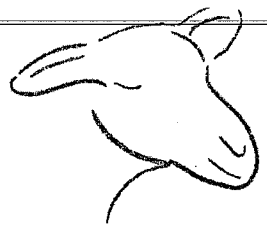
It is your responsibility to notify the office of any changes to your insurance coverage. _____

Referrals: If your insurance plan requires a specialty referral, it is your responsibility to notify the office 1 week prior to the appointment date. You will need to provide all pertinent information needed to process your referral. _____

MISSED APPOINTMENT POLICY:

Your appointment time is reserved for you alone. If you are unable to keep your scheduled appointment, please notify the office 24 hours prior to any cancellation. Patients who miss multiple appointments without prior notification may be considered for discharge from the practice. _____

SIGNATURE OF GUARDIAN _____ **DATE** _____



PL Physicians, Inc.-Health History

Name:_____ Date of Birth: ___/___/____ Sex: M F

Mother's Name: _____ Age:____ Fathers Name:_____ Age: ____

Occupation:_____ Occupation: _____

If adults in the household work outside the home, what childcare arrangements are made for this child?:_____

_____

A. Pregnancy and Birth: (circle "Yes" or "No" leave blank if uncertain)

1. Did the mother have any illness during the pregnancy?..... Yes No
2. Were any other medications other than vitamins and iron taken during pregnancy?..... Yes No
3. Was the baby born on calculated due date?..... Yes No
4. What was the child's birth weight?..... _____
5. Did the baby have any trouble starting to breath?..... Yes No
6. Did the baby have any trouble while in the hospital? (Jaundice, infection, other?)..... Yes No

B. **Past Medical History:** (circle "Yes" or "No" leave blank if uncertain)

1. Where has your child gone for check-ups until now?..... _____
2. Date of last check-up?..... _____
3. Date of last dental check-up? (if applicable)..... _____
4. Has your child had allergic reactions to any medications, food, insect bites, or immunizations? Yes No
5. Any hospitalizations other than for birth?..... Yes No
6. Any serious injuries, or broken bones..... Yes No
   If "Yes" please give details:_____
7. Are any medications taken regularly? Yes No
   If "Yes" please list:_____

C. Family History:

1. Are the child's parents both in good health?..... Yes No
2. Circle any diseases that this child's parents, grandparents, siblings, aunts, or uncles have had:

Anemia	Drug problems	AIDS/HIV	High Blood Pressure
Asthma	Alcohol Problems	Learn Disabilities	Heart Trouble
Allergies	Inherited Illness	Thyroid Problems	Tuberculosis
Diabetes	Cancer	Blood Conditions	Mental Illness

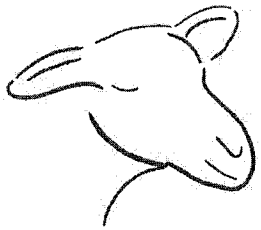
3. List age, sex and general health of siblings: _____

_____

4. Have any of your children passed away?..... Yes No

D .Feeding and Nutrition:

1. Is your child's appetite usually good?..... Yes No
2. Is it good now?..... Yes No
3. Was there severe colic or any unusual feeding problem during the first three months?.. Yes No
4. Do any foods seem to disagree with your child?..... Yes No



Pl Physicians, INC- Signature of Understanding and Acknowledgement

By singing below I state that I _____ (responsible party) have read and understand each of the provide materials, also that I have been offered a copy upon request of all stated policies. **(Please ask reception for a copy of any information that you have read and are signing for if you wish to have them for personal records.)**

PL Physicians, INC- Office Information:

_____ _____

Signature **Date**

PL Physicians, INC- Office Policies and Procedures:

_____ _____

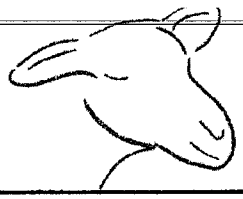
Signature **Date**

PL Physicians, INC- Notice of Privacy Practices:

_____ _____

Signature **Date**

Please be advised that this information is also available on our website WWW.PLPHYSICIANS.COM



PL Physicians, Inc-NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: August 1, 2013 This Notice was revised on August 1, 2013.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Mr. Dana Tate
Mailing Address: P.O. Box 845, Fredericksburg, VA 22404
Telephone: (540) 371-4488
Fax: (540) 371-2748

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights -and we have certain legal obligations - regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

"Protected Health Information" is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.

- **For Payment**. We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health Care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical Necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.

- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We

- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.

- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.

- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.4

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fund raising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Most uses and disclosures of psychotherapy notes;
2. 2. Uses and disclosures of Protected Health Information for marketing purposes; and
3. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by

we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.

- **Out-of-Pocket-Payments**. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

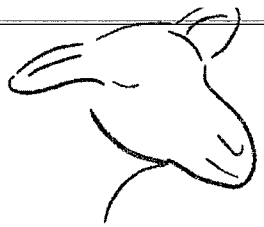
Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.



PL Physicians, Inc.-Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day to day activities and management of PL Physicians, Inc. for example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates: We are permitted by law to utilize Business Associates to carry out treatment, payment or health care operations functions that may involve the use and disclosure of some of your health information. For example, we may utilize a billing service to handle billing and payment functions.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment with our practice.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and disclosures require your authorization: Disclosure of your health information or its use for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke this authorization will not affect or undo any uses of disclosures of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights:

You have certain right under federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical conditions and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and whom your protected health information has been disclosed
- The right to receive a printed copy of this notice.

PL Physicians, Inc. duties:

We are required by law to maintain the privacy of your protected health information and to provide you with a copy of this notice of privacy practices.

PL Physicians, Inc. Inc.-Office Information

We have found it helpful to acquaint new patients with our office routine. We hope the following information will assist you in obtaining the services available in our office when you need them.

Regular Office Hours

Monday through Friday 9am-5pm. The office does close for lunch each day from 12:30pm-1:30pm, however our phones remain on. It is only during these "regular office hours" that well-child checkups are scheduled. Each day we reserve specific time for well-child (physical) checks and for sick visits. Frequently, our time for well-child examinations is filled weeks ahead; therefore, try to anticipate well in advance your need for camp, school, athletic, and other examinations with a deadline.

Weekend Hours

Saturday mornings from 9am-12pm at 4550 Empire Ct. Fredericksburg VA 22408, a doctor from our on call group will be open for sick visits. We work on a first come first serve basis and we do not schedule in advance. These hours should be reserved for URGENT problems which cannot reasonably await "regular office hours."

Whenever the office is closed, a physician is always on call. If the office is closed, you will need to call the office service directly at (540) 361-4779. There is a Mary Washington Hospital Healthlink Nurse available when the office is closed. You can also call the number provided on your insurance card for advice free of charge.

How to Telephone the Office

1. Call (540) 361-4779
2. Make the phone call yourself if at all possible. Relaying the message through a third party may result in misleading information.
3. Identify yourself and give your child's full name and date of birth. Describe the condition in specific terms and be sure to state if the child was seen recently for the condition.
4. Have a pencil and paper ready when you call. Do not rely on remembering instructions – especially when you may be upset.
5. If the receptionist is unable to solve a problem which is not urgent, your phone number will be taken and a nurse will call you back between office patients, but by the end of the day.
6. Call us, if at all possible, before rushing to the emergency room, so that the necessary arrangements can be made.

Hospital Affiliations

Please note that our doctors direct admit patients to Local Emergency Rooms. A pediatric hospitalist will follow your child's care while admitted except for newborns.

Appointments

We realize that your time is important, and it is inconvenient and irritating to wait for long periods in the doctor's office. We have implemented a schedule which allows us to see patients with minimal delay. Everyone in our office is alert and committed to this goal. There are several things you can do to help us in this effort:

When you call for an appointment, briefly inform the receptionist of the problems you wish to discuss with the doctor. This helps her schedule an appropriate amount of time for your child. Most problems can be handled in a routine appointment. Others such as family, school, and behavior problems require much more time.

If you decide to bring a sister or brother along to be seen also, please ask us prior if time is available so the chart can be prepared in advance and more time can be allowed for your visit.

If a conflict arises and you cannot make your appointment on time, let us know and we will give you an appointment later in the day if possible.

Upon arrival in the office, check in at the front desk and have a seat. If you have not been called within 15 minutes of your appointment time, please check with the receptionist.

Please do not "walk-in" to be seen without an appointment unless the circumstance is unavoidable.

Telephone Advice

Many problems can be handled by phone without the necessity of an office visit. You should expect your call to be returned by the end of business. When necessary, the nurse will consult with one of the doctors. When the office is closed, calls should be limited to urgent problems that cannot reasonably await "regular office hours."

Immunization Policy

Immunizations are the cornerstone of pediatric medicine and have changed the landscape of medicine in the 20th century. PL Physicians, Inc. follows the recommendations of the American Academy of Pediatrics and the Centers of Disease Control. We feel very strongly that immunizations are one of the most important medical services we can offer your child. We welcome the opportunity to discuss any questions or concerns you may have.

Transferring From another Practice

If you are transferring to PL Physicians, Inc. from another practice, we appreciate your entrusting us with your child's health care. To help you request a transfer of your records from your previous physician, we have provided below a Record Release Form. The blank form may be printed and then filled out by hand, or you may fill out the form electronically while online, and then print the completed form. Be sure to sign the form, and then send it to your previous physician's office.

Transferring Out of the Practice

We are always sorry to have patients transfer out of our practice, but we understand that there are valid reasons for doing so. To help you request a transfer of your records to another office or clinic we have provided below a Record Release Form. The blank form may be printed and then filled out by hand. Be sure to sign the form, and we would appreciate knowing the reason for your transfer. The signed form may be brought, faxed, or mailed to our office to request to be transferred.

PL Physicians, Inc.-Office Policies and Procedures

In the effort of serve all of our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

Patient information and Insurance Cards: Your personal information sheet and insurance card are an important part of your medical record; it is your responsibility to make sure that you updated this information at each visit to keep your record current. As this may seem inconvenient, it is necessary to keep your insurance and contact information updated to insure you receive proper care.

Late Policy: Every effort is made to keep our physicians schedules on time; therefore if you are more than **15** minutes late, we may reschedule your appointment to the next available with a physician in the office; however, there is no guarantee that you will be seen immediately or by the originally scheduled physician, if all physicians' schedules are full you will be asked to reschedule your appointment to a later date.

Missed Appointment: Every effort is made to accommodate our patient's requests for appointments. Therefore, it is important that you make every effort to keep your scheduled appointments. No-show appointments will be subject to a fee of $25.00. Please be advised that chronic missed appointments may result in dismissal from our practice.

Transferring of Records: All patients must sign a records release form to have their records copied or to send them to another provider or organizations. Copies will be provided to the patient or another provider for a **$10.00** administrative fee PLUS **$0.50** per page up to 50 pages and **$0.25** per page thereafter.

Payment for Services for patients with Insurance: According to your health insurance plan you are responsible for paying your co-payment at the time of service. If we participate as providers with your health plan we will bill your insurance company for your visit. If we are not contracted with your insurance company, you are responsible to pay for your visit after the services are rendered; PL Physicians, Inc. files your insurance as a courtesy. We ask that if your account remains unpaid after 45 days that you contact your insurance company for payment.

Payment for Services for patients without Insurance. You will be responsible for payment by cash, Check, or Credit Card on the day of service. On a bill with extensive procedures and by approval of out billing department and office manager, you may set up a payment plan with our office.

Returned Checks: There is a **$50.00** fee for any checks returned by your bank.