HUB CITY Family Practice LLC

19426 Leitersburg Pike
Hagerstown, MD 21742
Phone: 240-513-6330
Fax: 240-513-6332

OFFICE POLICIES

Hub City Family Practice has a no-show policy. Our policy states that a patient must give a 48-hour business hour notice of cancellation so we may offer that date/time slot to someone else in need of an appointment.

Our no-show fees are as follows: **NEW PATIENT** : Will not be rescheduled
ESTABLISHED PATIENT: $45
PRE/OP, PROCEDURE: $100

LATE APPOINTMENT POLICY

Established patients will be asked to reschedule if 15 min. late for your appointment. You will also be billed $25.00. **Follow-up appointments will not be scheduled until balance is paid.*
Please call our office at **240-513-6330** if you know you will not be able to make your appointment.

PAYMENT POLICY

Unless prior arrangements have been made, we request full payment at time of service. If your check is dishonored by your bank, your account will be assessed a $25 non-sufficient funds fee. Any account past due over 30 days(from date of service) will be assessed a late fee of $15 per month.

AUTHORIZATION RELEASE

I authorize HUB CITY FAMILY PRACTICE to release any medical information including diagnosis, x-rays, test results, reports, records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for diagnostic, insurance, legal, and research at times my provider deems necessary in order to ensure the best medical care on my behalf. I further understand that any person that receives these medical records will not release any medical information obtained by this authorization to any other person or organization without further authorization signed by me for release of information. This office protects patient's information in accordance with the Health Insurance & Accountability Act (HIPPA). My signature below indicates my authorization and acknowledges that I have received information on our office Privacy Practices

I have read and agree to the policies as outlined above:

_____ _____/ _____/ _____
Patient / Guardian Signature (relationship to patient) or Power of Attorney Date

Print Name: _____

Thank you for choosing Hub City Family Practice for your Healthcare needs.

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