**PATIENT OFFICE POLICY NOTIFICATIONS**

1. I understand that Partners in Family Medicine participates with **McLaren Macomb Hospital Lab**. If my lab work is required to go to a different lab, per my insurance company, I agree to inform the medical assistant prior to testing at each office visit.
2. If your insurance company requires a prior authorization before any diagnostic services are performed at an outpatient facility, please allow at least 7 days from the time you schedule your diagnostic test for PFM staff to obtain the authorization from your insurance company.
3. If your insurance company requires a prior authorization for prescribed medication, please allow at least 7 business days for PFM staff to obtain authorization from your insurance company. That means you should contact the office no less than 7 days before your current medication is gone.
4. Some insurance plans require a deductible, copay, or co-insurance payment as part of your contract. These contract obligations are collected at the time of service.
5. For your convenience, please request medication refills at the time of your appointment. If you are calling the office directly for refills please allow 24-48 hours for refills to be sent to your pharmacy or printed for pick up in the office.
6. To protect your personal health information prescriptions, test results and paperwork will only be given to persons Iisted on your release of information form. No exceptions.
7. I understand I will be assessed a fee if I “no show” (no call no show) to a scheduled appointment.

By signing below I acknowledge that I have read and understand the above office policies:

X

**Signature of Patient/Representative Date**

**Printed Name of Patient Date of Birth**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

By signing below, I am aware of Partners in Family Medicine Notice of Privacy Practices and can request a copy at any time.

X

**Signature of Patient/Representative**  **Relationship Date**

**Witness**