



At Access Health Sebastopol we strive to provide the most up to date treatment options that will benefit you. The following document helps prevent confusion about your responsibilities in treating your medical condition. Please read the below information carefully.

Financial Responsibility

You are responsible for all costs of your treatment. Your insurance may or may not cover all the cost associated with the plan of care pursued by you and your physician. All copays are due at time of service. As a courtesy to you, we will bill and collect the amount allowed by your insurance contract for your treatment. We are not responsible for insurer's inadequate payment, unreasonable payment delays or claim denials. We do our best to make sure planned treatments are preauthorized for, however, we advise that you verify your insurance benefits before undergoing any treatments, procedures, or surgical intervention. Please be aware that certain services are not typically covered under the scope of routine office visit by your insurance and as such, are billed below:

Appointment No Show	\$50
Late Cancellation Fee	\$50
Return Check Fee	\$25

Late Arrival Policy

Please be aware that if you are late to your appointment, you may be asked to reschedule your visit, or you may have to wait until we can fit you in after on-time arrivals have been seen.

Cancellation Policy

If you need to cancel your appointment, please contact the office 24 hours before your scheduled time. We understand that 24hrs notice may not always be possible, however, we will still require a minimum of 2hrs notice to cancel your appointment. If we do not receive sufficient notice a Late Cancellation Fee can be charged to your account.

Phone Call Policy

Our office receives a tremendous amount of phone calls each day. In order to devote the appropriate care and attention to each patient in the office, our physicians and/ or office staff typically return calls during the lunch hour or after regular business hours. The medical board of California discourages physicians from providing treatment information over the phone; therefore, if you are experiencing a new problem, please schedule return visit to discuss the issue in person. **If you are experiencing a life-threatening emergency, please call 911.** In general, we are not available to discuss issues over the phone with multiple family members. If you believe you will have difficulty remembering treatment recommendations discussed during your visit, please bring a family member to assist with note taking and recollection.

Insurance Release Policy

I hereby authorize the release of any medical information necessary to process an insurance claim. I understand that I will be responsible for all non-covered services, including out of network charges, and any denial not covered by my medical insurance program.

Medication Refill Policy

You are responsible for keeping track of your own medications. No prescription refills for lost medications will be issued **Please allow 72hrs notice for all prescription refill requests**. Please note, without 72hrs notice there is no guarantee your prescription will be filled. Refill requests are most easily made by calling your pharmacy or calling your physicians medical assistant. By signing below, you are giving Sebastopol Urgent providers authorization to communicate verbally, electronically or in writing to your pharmacy or other providers regarding your current medications.

Pain Medication Policy

In addition to the above Medication Refill Policy, these further guidelines apply to controlled substances: all controlled substance prescriptions must be picked up in person with photo ID. All prescriptions for controlled substances must be filled by one medical office at one pharmacy. Evidence of obtaining a controlled substance by more than one medical office or using multiple pharmacies without prior disclosure is grounds for discontinuation of controlled substance refills. By accepting a controlled substance prescription from our offices, you grant our physicians and staff permission to discuss aspects of your care and medications with all involved physicians, hospitals, and pharmacies as medically necessary.

By signing this document, I acknowledge that I have read, understand, and accept the policies noted above.

Patient Signature: _____

Print Name: _____

Authorized Persons:

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

**Acknowledgement of our Notice of Privacy Practices and
Consent to Obtain Prescription History**

I agree that Sebastopol Access Health Sebastopol may request and use my medication History from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. I hereby acknowledge that I have received or have been given the opportunity to receive a copy Access Health Sebastopol Notice of Privacy Practices (A laminated copy is available at the front desk. Additionally, I may request a hard copy at any time). By signing below, I am giving acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy Practices. I am also authorizing you to release and or discuss my healthcare information with the following persons.

Patient Signature: _____ Date: _____

Print Name: _____

Authorized Persons:

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____