Montgomery Internal Medicine Group, PC

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Patient Welcome Letter

Dear Patients of Montgomery Internal Medicine Group:

We are pleased that you have chosen Montgomery Internal Medicine Group for your medical care. Please read the following information so that we may make your experience with our practice a positive and productive one.

Prescription refills: Before calling our office for a refill, please check with your pharmacy if any refills are present. For proper medical care, patients **MUST** be seen within **6 months** to obtain a refill. If your insurance company requests a 3 month mail in order, please allow ample time for the order to be received through the mail. The patient is responsible to mail in the prescription. Refill requests may take up to 2-3 business days to be processed. Always check with your pharmacy first, before picking up your prescription.

Referrals: Our office staff requests that you give at least seven (7) working days notice to process a referral to a specialist under your managed care plan. (Please ask for our referral form outlining the referral process.)

No Show and Cancellation Fee: A 24-hour cancellation notice is required for all appointments. A fee of **$30** will be implemented if required notice is not given.

Medical Records: Written authorization from the patient/parent or guardian must be obtained to release medical records. At **least** one week's notice is required to complete your request for medical records. The cost is $1 per page when records are released directly to the patient. There is no charge if records are forwarded directly to a new physician.

Our private pay and non-insured patients will be asked for payment at the time of service. We accept assignment on Medicare patients.

Over the last few years our telephone call volume has increased exponentially. We make every effort to answer calls and return messages in a timely fashion. That having been said, there may be times when the call volume is such that you may be asked to leave a message or be put on hold in order to handle the calls in an orderly and professional manner. Please understand that we will do our best to handle all calls as quickly and efficiently as we can. Any medical emergencies will be handled immediately by calling our emergency number which is 609-683-8894. Thank you for your cooperation.

PAYMENT IS REQUIRED AT THE TIME SEVICES ARE RENDERED.

A FEE OF $25 WILL BE CHARGED FOR ALL RETURNED CHECKS.

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY OUR OFFICE OF ANY INSURANCE AND/OR DEMOGRAPHIC CHANGES.

Payment Policy

Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. Always contact your insurance carrier first to ensure we are a participating provider. If you are insured by a plan we are not contracted with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you have regarding your coverage.

2. **Co-payments.** All co-payments **must** be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services at time of service or within **14** days of billing statement.

4. **Proof of insurance.** We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

5. **Claim submission.** We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Payment Policy subject to change without notice.

I have read and understand the payment policy and agree to abide by its guidelines.
Print Patient Name _____

Signature of patient or responsible party _____ **Date**_____

Montgomery Internal Medicine Group

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Montgomery Internal Medicine Group, PC, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Montgomery Internal Medicine's, PC Notice of privacy practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Montgomery Internal Medicine Group, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our offices at 727 State Road, Princeton, NJ 08540 or 719 Rt. 206, Suite 100, Hillsborough, NJ 08844.

With my consent, Montgomery Internal Medicine Group, PC, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I wish to be contacted in the following manner (mark all that applies):

Home telephone_____
OK to leave a message with detailed information YES NO
Leave a message with name of practice and call back number only YES NO

Cell phone_____
OK to leave a message with detailed information YES NO
Leave a message with name of practice and call back number only YES NO

Work phone_____
OK to leave a message with detailed information YES NO
Leave a message with name of practice and call back number only YES NO

I grant permission for you to discuss my care with the following person(S):

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

Name_____ Relationship_____ Phone#_____

By signing this form, I am consenting to Montgomery Internal Medicine Group's, PC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Montgomery Internal Medicine Group, PC may decline to provide treatment to me.

_____ _____ _____
Print Name of Patient/Legal Guardian Effective Date of Consent Expiration of Consent

_____
Signature of Patient/Legal Guardian