**FPIM of New Haven County, LLC 205 Main Street East Haven, CT 06512**

Phone: (203) 466-5070 Fax: (203) 466-5075

We ask that you read and sign this form to acknowledge your understanding of our Office Policies and Consent.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL RESPONSIBILITY POLICY**

I acknowledge that it is ultimately my responsibility to pay for treatment and care. FPIM will bill your insurance; some insurance companies will only pay for services they deem “Medically Necessary” and deny services they deem “Not Medically Necessary.”

I acknowledge it is MY responsibility to provide the most correct and updated information regarding insurance.

I acknowledge I am responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatments not covered by their insurance plan. **This includes any procedures or testing related to a Complete Physical Exam, for example, EKG, HEARING, AND BLOODWORK.** I hereby authorize the assignment of financial benefits directly to FPIM of New Haven County, LLC.

**APPOINTMENT POLICY**

I acknowledge I am to arrive 10-15 minutes before the scheduled appt time

I recognize a SAME DAY CANCELLATION**/NO SHOW fee of up to $50.**

I acknowledge that I WILL CONFIRM my appointment. **If I do not confirm FPIM reserves the right to CANCEL the appointment**

I acknowledge that FPIM of New Haven County, LLC reserves the right to discharge me from the practice for frequent NO SHOWS, R/S, OR CANCELLATIONS, non-payment of balances, or disruptive or inappropriate behavior.

**TREATMENT CONSENT**

­­­I consent to allow the providers of FPIM to perform necessary medical examinations and tests to diagnose and treat my health conditions.

I understand that Insurance companies recommend specific testing and screenings to treat and diagnose patients correctly.

I have the right to have a chaperone present with my provider.

I have the right to discuss any treatment with my provider. I am encouraged to ask questions about any concerns I have.

I under that if additional testing or treatment is needed, I will be asked to read and sign additional forms.

This consent is valid until I revoke it in writing.

 I agree that my medication/prescription can only be given to me on my regular office visits. A missed visit may result in not being able to get my medications/prescription until the next scheduled visit. I agree to schedule an appointment for **5-7 business days before** running out of my medications.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read, understand, and agree with the provisions of the Patient Policies and Consent.