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

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

Please read and sign this form to acknowledge your understanding of our Policies, fees, and consent.

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

**FINANCIAL RESPONSIBILITY POLICY**

I acknowledge that my responsibility is ultimately 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.

**BILLING (once visit is complete)**  \*\* Does not apply to amounts due on date of visit \*\*

* I acknowledge that when the amount owed is determined, please send me a bill. I will pay within 28 days. If I do not pay within 28 days my account will be turned over to collections, an additional 30% finance charge will be added.

**APPOINTMENT POLICY/FEES**

Late cancellation of appointment (24 hours’ notice is required) $25.00-$50.00

Appointment NO-SHOW $50.00

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.

**FORM FEES**

Disability/FML $30.00

Nursing School forms $30.00

Medical records .65 per page

**TREATMENT CONSENT** I consent to allow the providers of FPIM to perform necessary medical examinations and tests to diagnose and treat my health conditions. 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. To provide our patients with knowledge that your insurance company may not offer. We want to explain how the ***Annual Physical/Wellness exam is billed***.Your insurance company may tell you, YOU are entitled to a “FREE PHYSICAL.” That means one service (billing code) is associated with the word PHYSICAL or ANNUAL PREVENTATIVE VISIT. This and only this code is covered 100% per your insurance contract. As part of our commitment to providing you with the highest level of primary care services, your provider will conduct various tests and other services during your physical to address all your medical needs. It's important to note that these additional services may be subject to copays, deductibles, and coinsurance. Understanding this aspect of your insurance contract can help you prepare for potential costs, and you can take control of your healthcare costs by discussing this information with your insurance company.

***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 policies, fees, and consents**.