Liberty University Health Services

WELCOME to Liberty University Health Services. It is our goal to serve you in a caring and professional manner. We feel it would be helpful to make you aware of the following.

CONFIDENTIALITY: We realize that confidentiality is a very important part of your treatment. Therefore, we do not release any information regarding our patients without the patient's signed consent except in the case of Court Subpoena or as requested by your insurance company. You will sign a release on your encounter form to bill your insurance and release any information they request to get your claim paid.

AFTER HOURS AND HOLIDAYS: Normal business hours are 8:30am to 5:00pm, Monday-Friday. In case of an after hours emergency, the voicemail will instruct you to call the doctor on call. There is a physician on call 24 hours a day. If you anticipate a call back from your provider, please remove all Call Blocks from your telephone.

CANCELLATIONS/MISSED APPOINMENTS: In order to best allocate your provider's time, unless you have an emergency, 24 hours notice is required for cancellation or you will be charged $35.00 for missed appointment. You will be responsible for this charge. After three missed appointments, you may be discharged from the practice (at your provider's discretion) due to noncompliance with treatment recommendations. It is our policy to make reminder calls of your appointment. Please notify the receptionist if you do not want messages left at your home.

MEDICATION REFILLS: Please make sure that you receive from your physician at the time of your appointment, enough medication to last until your return follow up appointment. If you need medications refilled prior to a scheduled appointment please call your pharmacy to verify no additional refills remain. The pharmacy will then contact our office to request the refill. Please talk to your physicians before making any medication changes. **24 Hour notice is required to process refills.**

CONCERNS, QUESTIONS OR SUGGESTIONS: In order to foster optimal therapeutic relationships, please direct your concerns, questions, or suggestions to your provider. If your concerns cannot be resolved you will be asked to speak with the Office Manager.

ADDRESS, INSURANCE, TELEPHONE CHANGES: Please notify our receptionist of any change in your address, telephone number, or insurance information. If you do not notify our office of new insurance prior to your appointment, you will be required to pay in full at the time of service.

FILING INSURANCE: I understand that Liberty University Health Services will file primary insurance but follow up on insurance payment and payment of the bill is ultimately my responsibility and that I must pay any portion due by me at the time of service. I also understand that it is my responsibility to check with my insurance company or my primary care physician and obtain referral if one is needed and if I do not get the referral I will be responsible for all charges incurred. I understand that I am responsible to file any claims other than my primary carrier, unless required by a contract between my insurance carrier and Altavista Medical Center. **Please list anyone other than yourself that you authorize our staff to discuss your account with:** _____

PARENT/GUARDIAN: The parent or guardian who brings in a minor will be held responsible for the co-pay or any amount the insurance does not pay. We do not honor divorce decrees or do split billing between parents who are separated or divorced. Parent or Guardian must be present for minor's appointment or provide written permission for treatment.

WORKMAN'S COMPENSTAION: If your claims are Workman's compensation, it is your responsibility to provide us with your Award Order or a letter from Workman's Compensation with a contact name and number and verification that your claims will be paid.

I have read and fully understand the policies outlined above and agree to comply. I have received a copy for my own records. I have also received a copy of <u>Your Rights and Responsibilities as our patient.</u>

_____	_____	_____
Patient/Parent/Legal Guardian	Witness	Date