

Patient Name: \_\_\_\_\_

We would like to welcome you to our practice and provide you with useful information before your first visit. The following points should be kept in mind to avoid delays or the need to reschedule. Please read these points thoroughly, sign below, and bring this form to your appointment.

- Please try to arrive on time. We do our best to stay on schedule and by arriving on time You will help us stay on time. Your first appointment allows 30 minutes to complete the registration process. If you are 20 minutes or more late for your first appointment or a future follow-up appointment, you will be rescheduled.
- Please bring all of the medications you are currently taking, not just a list; your actual Medication bottles.
- Have all paperwork sent to you **THOROUGHLY COMPLETED** prior to your appointment.
- Bring your insurance card(s) and driver's license or picture ID. If you do not have your Insurance card the day of the visit, you will be required to pay for the visit that day.
- If you are not the primary subscriber for your insurance, we will need to know the Name, Address, Date of Birth and Social Security Number of that person in order to bill the insurance. If you do not know that information we cannot bill your insurance and you will be required to pay for the visit that day.
- If your insurance company requires a referral, it is your responsibility to get one from your Primary Care Physician. If this referral is not in our office at the time of your visit, you will need to reschedule your visit or agree to pay for the visit that day.
- Co-pays are due at the time of service. It is your responsibility to bring with you the entire amount of your co-pay, we accept cash and credit card including Mastercard and Visa. WE DO NOT ACCEPT CHECKS.
- Bring copies of relevant labs and x-ray reports, or have your physician fax or mail them to us. We suggest calling a day or two ahead to see if we have them in our office.
- **All cancellations or reschedules require a 24-hour notice. Failure to give a 24-hour notice will result in a fee.**

By signing below, you acknowledge that you have read and agree to the above policies.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date