Carlisle Family Care

1533 Commerce Avenue, Suite 1, Carlisle, PA 17015 Phone (717)240-1322 Fax (717)240-0382

Welcome to Carlisle Family Care. We are happy that you have chosen to become our patient. In order to ensure a positive relationship, we ask that you read and acknowledge the following practice policies. If you have any questions or need further clarification, please do not hesitate to ask.

- **Appointments -**Help our providers stay on time by arriving early for your appointment. If you are more than 15 minutes late, you may be asked to reschedule your appointment.
- **Medications -**It is important that you bring along your medication bottles, or an up to date list of your medications to every visit. This will ensure accuracy of medications and clarify the need for refills.
- **Medication Refills -**When requesting medication refills a minimum of 48 hours is required.
- **Insurance Referrals-**When requesting an insurance referral a minimum of 48 hours is required.
- **Co-payments -**Insurance co-payments are due at the time of the service. If you do not have insurance, we offer a 20% courtesy discount if you pay for the entire balance at the time of service. If you cannot pay for the entire balance a minimum payment of $50.00 is required.
- **Reminder Calls -**You will receive a reminder call 24-48 hours before your appointment. If you are unable to come to a scheduled appointment, it is important and respectful to notify our office in advance. If you do not notify our office you will be charged a $25.00 fee, and could be dismissed from the practice after three missed appointments in a twelve month period.
- **Physical forms –** If you have a form that needs filled out for a physical and you have had a physical in the last six months, we will complete the form using the date of the previous examination. If it has been more than six months since your last physical, you will be required to make an appointment for a new physical.
- **Forms –** There is a charge for the completion of forms ranging from $10 to $25. That fee must be paid when picking up your form(s).
- **Collection Balances -** If your account is presently in collection, the physician may use his or her discretion as to seeing you and your dependant again. It may be required that you pay your previous balance prior to being seen.
- **Medical Records –** Please be aware that we utilize an outside service to copy/transfer medical records. These requests can take between 30-45 days to complete. Please also be aware that there is a fee when asking our office to copy, fax or mail medical records. The fee is determined upon the number of pages copied. Payment will be required when picking up records, or prior to sending.
- **Minors -** All minors MUST be accompanied by a parent or legal guardian to receive care at our office. A minor is defined as under the age of 18. If a different adult/caregiver is accompanying the minor, a written note from the parent allowing us to treat your child must be brought to the appointment. A written note is required for each appointment.

-MEDICAL INFORMATION, INSURANCE PAYMENT AND PRESCRIPTION RELEASE-

I GIVE PERMISSION TO Central Penn Management Group, and its authorized employees, agents, and medical providers to release my medical information to insurance carriers, health maintenance organizations, governmental agencies, and other entities or individuals charged with the fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payments of the medical benefits otherwise payable to me to be paid directly to Central Penn Management Group and/or the appropriate provider. I consent to having any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I acknowledge and understand that in order to facilitate billing and related activities, my medical information will be maintained by CPMG on its computer network, and that all such information will be subject to appropriate measure to protect confidentiality. I also give consent to phone/fax prescriptions to my pharmacist.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PRACTICE POLICIES OF CARLISLE FAMILY CARE.

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Signature of Patient or Responsible Party Date