Michael S. Rogers, MD PA
South Jersey Family Medicine
Michael S. Rogers, MD
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831 Kings Highway, Suite 100
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OFFICE & FINANCIAL POLICY
ACKNOWLEDGEMENT OF HIPAA PRIVACY RULES

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. You are required to understand the contents of the contract. All non-covered services are the responsibility of the patient at time of service or billing.

REFERRAL POLICY: Referrals **will** be issued when medically necessary; when **72 hours** notice is given to our office; those ordered or approved by the office; when proper documentation is on file from your consulting specialist; when appropriate authorization has been obtained as required from your insurance company. Referrals **will not** be issued for any services performed prior to and/or without a referral (**No retroactive referrals can be issued);** referrals on demand for non-urgent services without prior specified notice. Pre-authorizations may require more time.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Charges are based upon the complexity and risks from the medical condition or its treatment.

PAYMENT: Payment is required at time of service including any co-pay designated by your insurance company. If we bill your insurance company and they do not pay within **45 days**, it will be your responsibility to pay the bill in full within **30 days** and resolve any issues with your insurance company. We will issue you a refund check if your insurance company pays. We accept **cash, check, and credit/debit cards displaying the VISA or Master Card logo** as payment. Non Sufficient Funds will result in a **$25.00** fee.

MISSED APPOINTMENTS: Unless cancelled at least **24 hours** in advance, you will receive a letter from our office. If a patient misses **3 or more** appointments without giving advance notice, the patient may be discharged from the practice. There will also be a **$20.00** fee for a missed appointment.

TREATMENT OF A MINOR: **Age 17 and younger** must be accompanied by a parent or legal guardian. Any other adult accompanying a minor must have a signed authorization from parent or legal guardian.

PRESCRIPTION REFILLS AND TEST RESULTS: Prescription refills and reviews of test or lab results will require you to make an appointment with one of our doctors.

COPY OF RECORDS: We require a signed authorization by a patient or legal guardian. **Age 17 and younger** requires a parent or legal guardian signature. We will send your records from this office to another physician's office for a flat fee of **$20.00**. If records are requested for personal use there will be a **$10.00 search fee** and **$1.00 per page** due from the patient in advance of issuing records. Records will be sent within **30 days** from the date we receive the request.

MEDICAL FORMS: There is a **$15.00 charge** for completing all Medical Forms with or without a visit. For example: School, Camp, Employee, Disability forms (except State), FMLA forms, and other forms from your employer. A visit is required for all forms with the following exception. Insurance will only pay for one periodic visit per calendar year. If you need a school, camp, or employee form filled in and have already had your periodic visit, we will fill in your form without a visit providing we have the necessary information from your periodic visit. If not, you will be required to schedule an appointment at a charge to the patient in addition to the form fee.

Thank you for understanding our Office and Financial Policy. Please let us know if you have any questions or concerns. I have read the Office and Financial Policy and understand and agree to this Office and Financial Policy.

X____Date____________________
Signature of Patient or Responsible Party

I (print patient's name) ____, acknowledge that I have received a copy of Michael S. Rogers, MD PA's Notice of Privacy Practices.

X____Date____________________
Signature of Patient or Responsible Party