

SUSSEX COUNTY MEDICAL ASSOCIATES

PATIENT'S RESPONSIBILITIES

**PROVISION OF ACCURATE AND COMPLETE INFORMATION:** I understand that I have the responsibility to provide accurate and complete information regarding symptoms, chief complaints, medications, past illnesses, family and personal medical history, address, insurance information, contact information, and any other information requested to assist in the provision of my care. I grant permission for release of medical and/or insurance information by Sussex County Medical Associates (SCMA) to any third party payers and/or agents for the purpose of any concurrent or retrospective review which may be required for processing a claim for payment. I also grant permission for SCMA to release all of my medical information to other treating specialists.

**FOLLOW THE PROVIDERS INSTRUCTIONS:** I also understand that I have a responsibility to follow the treatment plan recommended by the provider. This includes following instructions of the staff that function under the direction of the treating provider. I shall make it known whether I clearly understand the treatment plan and what is expected of me by the treating provider. I understand that there may be consequences if I refuse treatment or do not follow the provider's instructions.

**FOLLOWING THE PRACTICE'S RULES AND REGULATIONS:** I agree to be considerate of the rights of others by treating all staff, providers, and other patients with respect and courtesy. I understand that I am responsible to know the rules of my insurance plan regarding referrals and/or prior authorizations.

**ADMINISTRATIVE CHARGE FOR NON-PAYMENT AT TIME OF SERVICE AND CANCELLATIONS:** I understand that I will be charged a \$25 administrative fee for any co-pay or self-pay that is not paid at the time of service and must be billed. I also understand that it is my responsibility to give prior notice of a missed appointment except due to office closings. The 2<sup>nd</sup> missed appointment without notice is subject to a \$50 No-Show fee. The 3<sup>rd</sup> missed appointment without notice may result in discharge from the practice.

**ASSIGNMENT:** I understand that I am responsible for any and all co-pays, co-insurance, deductibles and/or services that are not covered and/or denied by my insurance carrier. I request that payment be made directly to SCMA by my insurance carrier for all covered services rendered to me.

My signature indicates that I have read, understand and agree with the above statements.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ DOB: \_\_\_\_\_