miracle hills clinic

health • wellness • beauty

Clinic Policies

Thank you for choosing Miracle Hills Clinic. We are committed to providing you with quality and affordable health care. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Consent to Medical & Surgical Procedures. The undersigned consents to the medical and surgical care and treatment, as maydeemednecessaryor advisable in the judgment of my physicianorother provider. Which mayincludebut are not limited to laboratory procedures, x-rayexaminations, medical or surgical treatment orprocedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physicians.______ *(initial)*

2. Controlled Substances. Some medications, such as opioids ("narcotics") require special prescribing rules. This is for your safety as they help you minimize the risks of overuse, side effects, and ensure proper use. Refills for controlled substances to patients are given at office visits only. We do not prescribe controlled substances to patients who are not known to our clinic or who have not selected MHC as their primary care provider. We do not provide refills at times earlier than those decided in the last visit. We ask that all patients receiving these medications receive prescriptions from one doctor and fill those prescriptions at one pharmacy. Any irregularities may lead to the end of the prescription.

3. Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copyof your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timelymanner, youmaybe responsible for the balance of a claim. ______ *(initial)*

4. Co-payments. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law bypayingyour co-payment at each visit. ______ *(initial)*

5. Non-Covered Services. Please beaware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessarybyMedicare or other insurers. ______ *(initial)*

6. Claims Submission. Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurancecompanyasa courtesytoyou.In order to properly billyour insurance company werequire that you disclose all insurance information including primaryandsecondaryinsurance, as well as, any changeof insurance information. Failure to provide complete insurance information mayresultin patient responsibility forthe entire bill. ________ *(initial)*

7. Coverage Changes. If your insurance changes, please notifyusbefore your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance companydoesnot payyourclaim in 45 days, the balance will automaticallybebilled to you. ______ *(initial)*

8. Non-Payment. If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we mayreferyour account to a collection agency and you and your immediate familymembers maybedischarged from this practice. If this is to occur, you will be notified by mailthat you have 30 days to find alternative medical care. During that 30-dayperiod, our physician will onlybeable to treat you on an emergencybasis.______ *(initial)*

9. Financing. We have made arrangements with Care Credit to offer patient financing. They have several programs available to help patients with medical bills. Please let us know if you would like more information. ______ *(initial)*

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10. Missed Appointments. When we schedule your appointment, we set aside that specific timeto address your needs and concerns. Appointments that are missed or canceled withless than 24 hour notice may be subject to a $25 no show/cancellation fee. This fee isthe sole responsibility of the patient and must be paid in full prior to patient's next appointment. Patients with 3 or more No Show Cancellations on short notice may be dismissed from the practice and denied any future appointments. ______ *(initial)*

11. Worker's Compensation or Motor Vehicle Accidents (MVA). It is your responsibilityto file a report with your employer or automobile insurance. If you are injured on the job, please let the receptionist know so we may contact your employer to facilitate filing your claim. If you are injured in a MVA, please bring your automobile insurance card. We will need the adjuster's name ad contact information. Until your MVA claim is settled, you will be held responsible for your charges. We will be happy to refund any money received from your auto insurance carrier.______*(initial*

12. Behavior. Our front desk staff are specially chosen and trained to help patients. We understand that there are many reasons why you may need to visit our office and we make every effort to make your visit as pleasant and comfortable as possible. In turn, we ask that your behavior is respectful of our staff. There is a zero tolerance for abuse of any kind and may lead to dismissal from our practice. If you have any problems associated with your visit, please contact our manager, Susan Browning. In order to provide you with the best possible care, a satisfactory doctor -patient is necessary. If for any reason, this relationship becomes compromised, then it may be best for both parties to end the relationship if necessary. If this occurs we will then provide emergency medical care for one month or when the patient finds a new provider, whichever comes first. _____ *(initial)*

13. Assignment of Benefits. Patient irrevocably assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission. ______*(initial)*

14. Notice of Privacy Practice Acknowledgment. I have received, read and understand you received your Notice of Privacy Practices in a more complete description of the uses and disclosures of my health information. I understand that Miracle Hills Clinic has the right to change it Notice of Privacy practices time to time and that I may contact this organization at anytime to obtain a current copy of the Notice of Privacy Practices ______ *(initial)*

15. Pharmacy. I understand that it is my responsibility to notify MHC of my pharmacy before prescriptions are sent. I understand that prescriptions may not be changed after they have sent it to the pharmacy. _______*(initial)*

Our practice is committed to providing the best treatment to our patients.

Thank you for understanding our policies. Please let us know if you have any questions or concerns. **I have read and understand the payment policy and agree to abide by its guidelines.**

______________________________ ______________

Signature of patient or responsible party Date

____

Printed name