F. Thomas Dean, M.D
Shannon L. Barnett, WHNP
Brandy M. Valentino, WHNP, CNM

WELCOME TO OUR OFFICE

Welcome to our office. Thank you for choosing our practice to take care of your obstetric and gynecologic needs. We know that you have a choice in selecting your medical care and we strive to provide you with the best service possible. Here are a few of our office policies.

Office Hours: Our office is open Monday through Thursday from 9:00am- 12:00pm and 2:00pm-5:00pm. On Friday the office opens at 9:00am and closes at 12:30pm. Office hours may vary during holiday seasons.

_____**NO-SHOW POLICY:** Patients are required to call the office at least 24 hours before their scheduled appointment time to cancel or reschedule. Patients that NO SHOW appointments will be charged a no-show fee of $50.00. Patients that no-show more than two appointments, without contacting the office, are at risk of being discharged from the practice at the providers discretion.

_____**FMLA Paperwork**: Patients requesting FMLA paperwork for their employers should expect up to 14 days for processing. The processing fee for paperwork is $35.00 and will be due prior to completion of documents.

_____**MEDICAL RECORDS:** Patients requesting a copy of their medical records for personal use will be charged a fee of $25.00 for the first 20 pages. Any additional pages will be a fee of $0.50 per page.

_____**NSF/Closed Accounts:** There will be a **$35.00** charge for return checks.

_____**INSURANACE POLICY:** Insurance card must be presented at each visit. Please notify office of any change in policy or coverage. It is the patient's responsibility to verify that F. Thomas Dean, M.D is contracted with the insurance company and in network. Signing this document gives Dr. F Thomas Dean, M.D. permission to release medical records to the insurance for billing purposes only.

_____**MEDICATION REFILLS:** Please request prescription refills through your pharmacy.

_____**CELL PHONE USAGE:** Our office policy is that once patient and guest are taken back and put into the exam room cell phones remain **off**.

_____**CHARGES:** Full payment is due at the time services are rendered unless other payment arrangements have been made with our billing specialist. Copays and balances are expected prior to service. After 90 days, outstanding balances will be referred to collection department. In the event your health plan determines a service to be "non-covered", you will be responsible for all non-covered and allowable charges. Delays in insurance processing occur when insurance information is not provided in a timely manner. Such delays may also result insurance denials. Denial's result in charges becoming the patient's responsibility.

_____NOTICE OF PRIVACY ACKNOWLEDGEMENT FOR F. THOMAS DEAN, M.D.

F. Thomas Dean, M.D Notice of privacy information. You have the right to review our notice before signing this acknowledgement. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health operations, as described in our Notice of Privacy. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent. This Privacy Acknowledgement does not give us consent to release records to anyone except the persons listed on the attached HIPPA form. A signed medical release authorization form must be completed prior to the release of records.

Thank you for understanding and agreeing to our Office Policies. We are committed to being an involved member of your Health Care Team.

__Signature of Patient or Guardian _____DOB

_____ Relationship to Patient _____Date

Patient Authorization and Consent

I consent to medical treatment by F. Thomas Dean, M.D. and associates. I authorize medical insurance benefits by assigned to F. Thomas Dean, M.D. I understand that I am financially responsible for fees, due at the time services are rendered, unless Dr. Dean's contract with my insurance plan states otherwise. The fee for no showed/missed appointments are **$50.00** (if plan permits). I am responsible for verifying and understanding my health insurance benefits. I will provide proof of coverage for each insurance plan to this office, with updates to policy information as they occur. My lack of attention to my insurance coverage (including referrals) may make me immediately responsible for today's charges. I give Dr. Dean and associates permission to leave messages at the contact phone number listed above. I will keep this office updated with any changes to my address, phone numbers, contact information and insurance information. I approve the transmission and maintenance of my protected health information electronically when necessary. I consent to the use and disclosure of protected health information about me for treatment, payment, and healthcare operations. I intend to update this form annually; however, I have the right to revoke my authorization and consent in writing at any time.

Signature: _____ Date: _____