Dr. Leonard Sukienik/WCIMS LLC

Acknowledgement and Understanding Office Policies 2022

Dear Patients,

We strive to provide you with the best medical care possible. Our office takes great pride in the individual service we give to each one of you. We will do our best to provide compassionate, committed and considerate care for all. The following are our guidelines so that we may maintain the standard of care you expect. Please be advised that current conditions may alter this agreement to protect the health, safety and welfare of all.

Office and Insurance:

- Please be advised that Professional Fees are due at the time service is rendered. This includes, but is not limited to, ***Copays, Deductibles* and the like**. Filing of primary insurance is a courtesy. Medical practices are not obliged to file your secondary insurance. It is up to the patient to make arrangements for that insurance to be filed, as is the case with insurance secondary to Medicare. This office will not file ANY insurances that are sent via paper. All claims are filed electronically per industry standard.
- It is acknowledged that the medical office will do their best to verify your policy is in force at the time of service. We will file claims for your **Primary Insurance**. **However, it is the Patient's responsibility to know the terms of their policy, their deductibles, referral needs and general limitations of the policy**. Patient acknowledges that they will disclose and be truthful about limitations, the requirements and limits of their policy. Patient acknowledges they will advise the office when there is a change of insurance status.
- Patient acknowledges that it is not the responsibility of the Physician or his staff to know the requirements of any insurance policy. Balances due after insurance is processed, because of deductibles, denial of claims, or lack of coverage at time of service, will become the Patients' responsibility. Delinquent accounts may be referred to a Collection Agency, where it may be subject to current allowable interest, collection fees, attorneys' costs and the like, in addition to the balance. Accounts need to be in good standing to receive services. Non payment of services may result in dismissal from the practice.

- Payment methods: Cash or credit card. Checks will be accepted under limited circumstances. Should a check be returned for payment a **$50 fee in addition to the balance** will be billed. NO checks will be accepted after that time. Accounts must be in good standing to receive services. We encourage you to call the office prior to your visit if you are unable to pay for services.

- It is strongly advised in the best interest of your health that all appointments times are expected to be kept. Should you need to cancel you must do so 24 hours in advance of your time. Appointments need to be rescheduled as required by the

Doctor. It is required that this office have a valid phone number and address on file in order to notify you of your appointment. Should we be unable to remind you of your appointment due to system outages beyond our control, you are still expected to keep or cancel your appointment as required. Notifications are a courtesy.

- The following charges apply if you do not cancel as required or NO SHOW for an appointment:

  1st occurrence: $50 2nd $75 3rd $100 and *possible discharge for non-compliance*.

Medications/Treatment:

- Patient understands that medications may not be renewed if they do not honor their commitment to keep appointments as requested. Requests for refills should be called in to your pharmacy or this Office during hours. Emergency, after hours and weekend refills will be available under limited circumstances
- The patient acknowledges that they will comply with the Physicians' recommendations which may include, but is not limited to, medications, tests, referrals to specialist, future appointments. The patient understands that it is their responsibility to communicate with the Physician when they are unable or unwilling to do so. It is further agreed that patients must communicate with this office should there be difficulties complying with recommendations. The patient understands that they have a right to refuse treatment as recommended by the Physician. Such refusal will be documented in the patient record per standard. It is understood that failure to comply with Physician's recommended treatment and/or medication may result in dismissal from the practice.
- Patient understands that controlled substance medications are filled on a scheduled basis and must meet certain guidelines per practice, their insurance and Florida statute. You will be advised of these guidelines at your visit. Failure to comply will result in dismissal.
- Medical Marijuana: The patient acknowledges that they will advise the Office immediately if they have obtained a medical marijuana card.

General:

- This authorization or photocopy thereof, will authorize the release of full and complete medical records when necessary to authorized physicians, hospitals, medical attendants, attorneys, insurance companies and the like. The patient acknowledges there may be fees involved in the photocopying or electronic transmittal of such records. It is understood that this office complies with all HIPPAA regulations pertaining to such patient records. No records or information will be released without a signed consent. The patient also acknowledges that there may be fees for filling out paperwork on their behalf that Lawyers, Employers and Insurance companies may not be willing to pay for. It is understood that all fees are due in advance of the paperwork being completed. We require a minimum of One week turnaround time on paperwork requests. Our fees are charged per current Florida statutes.

    - The completion of FMLA, Disability letters and such similar paperwork will incur a fee as posted in the Office. General return to work or sick notes are completed as a courtesy at the time of your visit.

- I authorize payment of medical benefits to the undersigned Physician for services rendered.

I have read and understood the above policy. I acknowledge that it may be necessary for this policy to be amended as circumstances require.

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Name:___________________________________

Parent or Guardian:______________________

Date:____________________________________

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