SAMPLE OFFICE POLICIES TO BE CONSIDERED

*This resource is designed for patients to review, sign, and return to the physician. Patients should also receive a copy of this policy.

Office Hours:

[Insert practice name] is open [insert office hours]. [Physician may consider including holidays on which practice is closed].

Appointments:

Patients will only be seen by appointment. Same day appointments may be made available in the event of emergency. To schedule an appointment, [insert instructions for scheduling appointment].

After-Hours, Holiday, and Emergency Coverage:

Our regular office hours are [insert office hours]. If you are calling after-hours about a matter that does not necessitate immediate attention, [insert instructions for leaving a voicemail] and we will return your call as soon as possible. However, if you are suicidal, fear that you will do harm to yourself or others, suspect you are having a severe allergic reaction to a medication, or face a life-threatening emergency, please call "911" or go to the nearest emergency room. You should instruct the emergency room to notify [insert physician's name]. For the sake of continuity of care, we ask that you bring any discharge instructions or medication adjustments to your next appointment.

Use and Disclosure of Health Information for Treatment and Payment:

[Insert physician's name] may use or disclose health information in order to provide and coordinate your health care, or obtain payment for health care services.*

I, (Patient Signature) _____, have reviewed, understand, and consent to the use and disclosure of health information for treatment and payment purposes. I also acknowledge that I have received a copy of [insert physician's name] notice of privacy practices with the effective date of [insert date].

*[Note: Health Plans may have notice requirements regarding disclosure of information for purposes of payment]

Payment:

Payment, including insurance copayments and deductibles, must be provided at the time of service. Please be aware that services provided may not be covered by your insurer, but you are ultimately responsible for payment of all services rendered. Any balance that remains outstanding for more than 90 days may be referred to a collections agency.

I, (Patient Signature) _____, have reviewed and understand the payment policy.

Appointment Cancellations:

In order to provide effective care, patients must adhere to the recommended treatment plan, attending and arriving on time for all scheduled appointments. If you need to cancel or reschedule an appointment, we ask that you provide advanced notice of [insert amount of notice required prior to appointment time]. If you do not attend your appointment and fail to give advanced notice, [insert consequence for failure to provide notice]. [If charging a fee, insert the following] You will be personally responsible for all missed appointment fees, as insurance companies typically do not reimburse for such charges.

I, (Patient Signature) _____, have reviewed and understand the appointment cancellations policy.

Prescriptions and Refills:

Please be advised that [insert physician's name] reviews the [insert state prescription monitoring program] before prescribing. [Insert physician's name] will not issue any prescription without first seeing you for an in-person appointment to evaluate your clinical needs.

[If using an electronic prescribing system, insert brief explanation of system].

If you are in need of a remaining refill, please contact your pharmacy. Your pharmacy will contact our office if authorization is required. Your refill requests will be processed within [insert time frame] after the receipt of your pharmacy's request. Prescriptions will not be refilled [insert time frames], so please plan accordingly. We reserve the right to decline issuing prescription refills if medications have been lost or stolen, or if you have missed an appointment.

Weapons:

To ensure a safe and productive treatment setting, [Insert practice/clinic name] prohibits weapons of any kind, with or without a permit to carry, in the office or on office property. Examples include, but are not limited to firearms, edged weapons, and chemical agents. With the exception of on-duty law enforcement officers, anyone found to be in violation of this policy will be asked to leave the premises.

I have reviewed, understand, and agree to all office policies set forth above.

Signature of Patient/Personal Representative	Date of Signature
Name of Patient/Personal Representative	Description of Personal Representative's Authority

Compliments of:

PRMS
Professional Risk Management Services, Inc.

Call	(800) 245-3333
Email	TheProgram@prms.com
Visit us	www.psychprogram.com
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