



Primary Care Specialists, Ilc.

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OFFICE PROCEDURE AGREEMENT

PATIENT LATE CANCELLATION AND NO SHOW FEES: Patients are required to give Primary Care Specialists, LLC. a minimum of 12-hour notice for a cancelled appointment. Appointments cancelled less than 12 hours in advance or patients who fail to show up for a scheduled appointment will be charged as follows: \$25.00 per missed appointment.

SICK PATIENTS: Sick patients must call the office as early as possible in the morning to be seen the same day. Otherwise, patient will be seen within 24 hours.

LABS AND LAB FEES: Patients must fast for at least 8 hours prior to all labs unless instructed otherwise. Labs may be drawn up to 4 p.m. as long as a patient remains fasting. Patients that desire for PCS, LLC. to draw blood understand that they will be charged a convenience fee of \$20.00. It is understood that this convenience fee of \$20.00 is not to draw blood and is not a "covered service". Patients have the option to go directly to a local lab where there is no similar charge.

PRESCRIPTIONS: Prescription refills will be processed within 24 hours.

ALL HMO PATIENTS: All referral requests must be made at least 72 hours (3 business days - not including weekends and holidays) prior to specialist appointments. If adequate time is not given, patient will be asked to reschedule the appointment. It is the patient's responsibility to notify PCS, LLC.

CELL PHONE USAGE: Cell phones must be placed on silent or vibrate mode upon entering the exam rooms.

INSURANCE: Current insurance cards must be presented at each and every visit.

PAYMENTS OF SERVICE: Co-pays and unpaid balances are required to be paid in full at the time of visit (no exceptions without prior authorization from the office manager or insurance billing department).

NSF: Returned checks will be charged a service fee of \$25.00.

FORM FEES: Fees range from \$10.00- \$25.00. These include handicap forms, disability forms, specialized forms and letters.

I have read and agree to abide by the office policies as stated above.

Patient Signature

Date

PRINT NAME