2418 E. Plaza Drive, Tallahassee, FL. 32308
Office: (850) 999-2651 **Fax:** (850) 765-2020

M·T·Th: 8 am- 5 pm, W: 10 am-7 pm, F: 8 am-noon, First Saturday of every month 8am-noon

Welcome to Tallahassee Perinatal Consultants, TPC!

Please read and complete each form. Thank you for allowing us to take part in caring for you and your baby during this special time. We look forward to serving you and your family.

Consent to Treat

I am presenting for care which may include obstetrical ultrasound, consultation, and genetic and/or diagnostic testing. I agree to have Tallahassee Perinatal Consultants and staff administer my care.

I understand that the physician and/or staff may recommend additional lab tests, procedures, ultrasounds, medicines and/or fetal monitoring.

When You Arrive:

Please sign in with front office receptionist.

Plan to arrive 15 minutes prior to your appointment time to enable proper completion of patient registration, new patient forms, and insurance verification. Please provide a picture ID, and insurance card (s) to scan into your protected file.

Communication between you and your physician is important to provide exceptional care to you and your baby; therefore, we encourage you to make arrangements for child care to avoid

distractions during your visit. We also request that you refrain from eating and cell phone use while in the office and exam room. We appreciate your understanding regarding these matters.

Payment policy:

Although we are contracted with several insurance companies, it is your responsibility to know your insurance benefits and to make sure that our physician is in your plan. If you do not provide us with correct insurance information, you will be responsible for all services rendered.

Please note that co-payments and charges not covered by your insurance will be collected at the time of registration ***prior*** *to seeing the physician.* This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles can be considered fraud. Please help us in upholding the law by paying your co-payment in full at the time of your service. *We accept cash, MasterCard, Visa, American Express, Discover, and debit cards as forms of payment.*

Claims submission. We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility regardless if your insurance company pays your claim. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Your insurance benefit is a contract between you and your insurance company; we are not aware of the specific details of your individual contract.

Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 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 may refer your account to a collection agency and you may be discharged from the practice. If this occurs, you will be notified by regular mail and certified mail that you have 30 days to find alternative medical care.

ALL REFUNDS MUST BE REQUESTED IN WRITING.

ANY RETURNED CHECKS FOR INSUFFIENT FUNDS WILL RESULT IN A $35.00 RETURNED CHECK FEE.

Late Appointment Arrival/Cancelling Your Appointment:

If you arrive 15 minutes or later after your scheduled appointment time, you may be asked to reschedule.

If you find it necessary to cancel or change your appointment, please notify the office at least 24 hours in advance to allow us the opportunity to serve another patient.

If you do not show for three consecutive appointments, and do not call to cancel or reschedule, you will be dismissed from our practice.

Diagnostic Results:

When lab results are returned to the office, they are first reviewed by the physician. As soon as they are available for our staff to review with the patient, the qualified staff will inform you of your results.

In some cases, you will be asked to return to the office in order to insure the results are explained in the manor to which is best understood.

Lab results may also be accessed in your patient portal.

When you need a form filled out:

We are happy to help you when we have advanced notice.

We are happy to accept medically related forms that require your doctor's signature.

Please fill out all information needed on the form about the patient, be sure to sign anywhere it states, "patient signature".

Once the pertinent information has been completed, please give the form to the receptionist so that it may be forward it to the appropriate staff to complete.

Please allow 5-7 business days for proper completion of your form.

Requesting Medical Records

You may request a copy of your medical record.

When referred to another facility for care, a complimentary copy of your medical records will be forwarded to the physician.

If you would like to receive a copy of your medical records, a medical release form will be required prior to them being processed. In addition, a fee of $1.00 per page will be required for processing.

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

Thank you for understanding our office policy. Please let us know of any questions.

Privacy Notice and Patient Rights

I confirm that I have read or received a copy of the notice of Privacy Practices. I know that I can get more information about uses of my medical record from that notice.

I confirm that I have read or received a copy of the Patient Rights and Responsibilities.

I give permission to Tallahassee Perinatal Consultants, LLC to release information to other health care providers that may be treating me as well.

Duration of Consent and Agreement

I understand that this agreement will need to be signed once per year for treatment at Tallahassee Perinatal Consultants, LLC.

I have read and understand the office policy of Tallahassee Perinatal Consultants, LLC and have no further questions or concerns. I agree to abide by its guidelines.

Signature of patient or responsible party Date