OFFICE POLICY- DR. MICHELLE E. SWIFT

Please initial each policy. This is to verify that you have read and understand our office policies and that you have had the opportunity to ask any questions.

_______ I understand that all appointments must be verbally confirmed by 5 p.m. on the previous business day. If I reach the answering machine, I will leave a message confirming my appointment. If this is not done, the appointment will be removed from the schedule.

_______ I understand that there will be a $35 fee for a missed appointment. This policy is for all patients. If there is a legitimate reason (at the Doctor's discretion) and/or the appointment has been cancelled at least 24 hours before, the fee will be waived. I will no longer be allowed to be seen as a patient in this office after the third missed appointment.

_______ I understand that if the patient is 15 or more minutes late for the confirmed appointment, the patient will not be seen. If this becomes a pattern, the patient will not be rescheduled. (This policy was created for our patients benefit. Seeing patients, who arrive later than 15 minutes after their appointed time, will delay subsequent appointments for the remainder of the day.)

_______ I understand that personal information such as phone numbers, home address, insurance, and place of employment must be current. If this information is not current and the office staff is not able to confirm an appointment because of this, I will be removed from the schedule.

_______ I understand that there will be no cell phone use in the operatories.

_______ I understand that if I have insurance, a deductible of $50.00 must be paid on the first visit of the year, along with any percentages that are due. Percentages are also to be paid for any service rendered at each visit thereafter.

_______ I understand that as a Medicaid patient, emergency and/or office visits where no actual procedures are done, are covered once per calendar year under the Medicaid policy and I am responsible for the charges if I go over the amount of visits allowed.

_______ I understand that as a Medicaid/insurance patient, if I am inactive on the day services are performed, I am responsible for all charges. As an Insured patient, I am responsible for calling my insurance, receiving coverage/benefits, and understanding them for myself.

These policies are to ensure that each patient's appointment is sufficiently handled with care and consideration. If you have any questions or would like to obtain a copy please speak to the receptionist.

I understand the policies that have been implemented.

Date: ________________________

Signed: ______________________