OUR NO-SHOW POLICY

PATIENTS WHO NO-SHOW TAKE AWAY THE OPPORTUNITY FOR ANOTHER PATIENT TO HAVE AN OFFICE VISIT.

TO AVOID A NO-SHOW FEE PLEASE GIVE US AT LEAST 24 HOUR NOTICE IF YOU NEED TO CANCEL YOUR APPOINTMENT.

A NO-SHOWN FEE OF $45.00 WILL BE APPLIED TO THE FIRST NO-SHOW FOR AN INDIVIDUAL PATIENT.

A $75.00 FEE WILL BE APPLIED IF A PATIENT HAS MORE THAN ONE NO-SHOW IN A 365 DAY PERIOD.

PATIENTS WHO CONTINUOUSLY NO-SHOW WILL BE NOTIFIED THAT THEY CAN ONLY SEE OUR PROVIDERS ON A WALK-IN BASIS IF AN APPOINTMENT IS AVAILABLE.

FAIRHOPE FAMILY MEDICINE NO-SHOW POLICY

There is a $45.00 No-Show fee to patients who miss their first appointment and do not call us in advance to cancel their appointment. The No-Show fee will increase to $75.00 for patients who have more than one no-show in a 365 day period. Similar to making a hotel reservation, we ask that a credit card be kept on file to hold future appointments. If you fail to show for a future appointment, by signing below, you authorize us to apply the appropriate No-Show fee to your credit or debit card.

This form must be completed to establish as a patient. The credit card on file needs to be the one you will make your in office payments with. By implementing the NO-SHOW policy we are trying to make sure that appointments are available when our patients need one.

If you have a medical insurance we participate with, we have agreed not to require payment for services we render to you on the date of service. However, you understand that we will require payment on the date of service for any co-pay, co-insurance or deductible amounts that we know your insurance will determine are your responsibility. If your insurance subsequently denies payment or applies additional amounts as patient responsibility and your balance goes into default, you authorize us to charge your credit card for the balance due.

Accounts are considered in default if left unpaid 45 days after payment is due. If a balance is not paid after the first statement we will add a $5.00 fee for each additional statement we send after the first statement. Your account will not be considered in default if you provide FFM with proof that you have disputed your insurance company determination of patient responsibility within 10 days of receiving the first statement from us and provide to us the phone call reference number that will allow us to verify that your insurance company is reconsidering the claim. We will give your insurance company 30 days to reconsider the claim after which we require payment be made. If you pay the amount due and your insurance company subsequently pays for the medical services in question, FFM will reimburse you any overpayment you have made.

This document will be kept by the Office Manager, Mark Andrade, in a secure locked location.

AUTHORIZATION TO CHARGE CREDIT/DEBIT CARD

I _____, hereby authorize Fairhope Family Medicine, LLC ("FFM"), to charge my credit or debit card the $45.00 or $75.00 No-Show fee if I fail to keep my appointment.

I also authorize FFM, to charge my credit or debit card if my account goes into default.

Type of card: _____ (We are set up to process only Visa or MasterCard)
Card number: _____ Expiration date: _____
Billing Zip Code: _____ Authorization Code: _____

I understand that this is an ongoing authorization. This authorization in no way compromises my ability to dispute a charge or question my insurance company determination that the amount due is my responsibility.

_____ Dated: _____
Signature