**PATIENT’S RIGHTS**

**MEDICAL CARE:** A patient has the right to receive considerate and respectful care and treatment without discrimination as to race, color, religion, sex, national origin, disability, and sexual orientation. A patient has the right to be informed of specific details about procedures, treatments and cost in order to make informed decisions about their care. This information shall include the possible risks and benefits of the procedure or treatment. The patients also have the right to refuse treatment and be told what effects this may have on your health.

**COMMUNICATION AND INFORMATION:** A patient has the right to be informed of the names and functions of all staff involved in their care, and to be supplied with an interpreter, if necessary. Patients have the right to participate in all decision about your treatment and to complain without fear of reprisal about the care and services you are receiving and to have the practice respond to your concerns. A patient’s questions or complaints can be addressed by the staff. Patients should follow the chain of command when registering a complaint, addressing concerns to the supervisor available at the time. If resolution cannot be obtained the patient can pursue the issue with the Practice Manager, and then the physician.

**MEDICAL RECORDS:** A patient may have access to his or her medical records. Patient’s medical records will be transferred to another provider upon written/signed request. Your medical records are the property of Sussex County Medical Associates and require signed permission from you (18 yrs. and older) prior to the release to anyone other than your provider of Medical Benefits or a treating specialist.

**PRIVACY AND CONFIDENTIALLITY:** Physical privacy shall be provided during any examination, test, and/or treatment. The staff shall maintain strict confidentiality and avoid speaking about a patient’s condition in public places and only discuss it on a need-to-know basis.

**PATIENT’S RESPONSIBILITIES**

**PROVISION OF ACCURATE AND COMPLETE INFORMATION:** I understand that I have a responsibility to provide accurate and complete information regarding, symptoms, chief complaints, medications, past illnesses, family and personal medical history, address, insurance information, contact information, and any other information requested to assist in the provision of my care. I grant permission for release of medical and/or insurance information by Regional Cancer Care Associates (RCCA) to any third party payers and/or agents for the purpose of any concurrent or retrospective review which may be required for processing a claim for payment. I also grant permission for RCCA to release all of my medical information to other treating specialists.

**FOLLOW THE PROVIDERS INSTRUCTIONS:** I also understand that I have a responsibility to follow the treatment plan recommended by the provider. This includes following instructions of the staff that function under the direction of the treating provider. I shall make it known whether I clearly understand the treatment plan and what is expected of me by the treating provider. I understand that there may be consequences if I refuse treatment or do not follow the provider’s instructions.

**FOLLOWING THE PRACTICE’S RULES AND REGULATIONS:**

I agree to be considerate of the rights of others by treating all staff, providers, and other patients with respect and courtesy.

**ADMINISTRATIVE CHARGE FOR NON-PAYMENT AT TIME OF SERVICE AND CANCELLATIONS:** I understand that I will be charged a **$25 administrative fee** for any co-pay or self-pay that is not paid at the time of service and must be billed. I also understand that it is my responsibility to give prior notice of a missed appointment except due to office closings. The 2nd missed appointment without notice is subject to a **$50 No-Show fee**. The 3rd missed appointment without notice may result in discharge from the practice.

**ASSIGNMENT:** I understand that I am responsible for any and all co-pays, coinsurance, deductibles and/or services that are not covered and/or denied by my insurance carrier. I request that payment be made directly to RCCA by my insurance carrier, for all covered services rendered to me.

**FINANCIAL POLICY**

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance provider. We accept VISA, MasterCard, and Discover Card.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company, in other words you have agreed to have your insurance provider pay us directly. As a service to you we will file your insurance claim if you assign benefits to one of our providers. If your insurance does not pay the practice within a reasonable time period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made arrangements with many insurance companies and other health plans to accept assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit. Your co-payment amount is established by your insurance plan. If you do not pay your co-payment you will be assessed an Administration Charge of $25 if we must bill you for your co-payment.
4. If you are insured by a plan that we do not participate with you must pay at the time of service and we will give you an invoice to be submitted by you to your insurance provider.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We will not re-code or alter the medical record in any way to bill for a service once deemed not-covered. You may appeal the decision to your insurance company.
6. We will bill your insurance for all physician services provided in the hospital. You are responsible for any balance due.

My signature indicates that I have read, understand and agree with the above statements.

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_