ALBUQUERQUE DERMATOLOGY ASSOCIATES & CUTANEOUS SURGERY CENTER, PA

Please Print Legibly & Fill In or Correct All Fields

Patient's Name: _____
Last First Middle

Address _____
Street & Apt # City State Zip

Primary Phone _____ Alternate Phone _____

May we contact you by Email? ❒ No ❒ Yes E-mail _____

Birthdate _____ Age _____ SS# _____

Sex ❒ Female ❒ Male Marital Status ❒ Single ❒ Married ❒ Other

Patient's Employer: _____ Wk Ph _____ Ext:_____

Address _____
Street & Suite # City State Zip

Emergency Contact:

Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

Mandatory: Failure to complete this section may result in cancellation/postponment of your scheduled appointment

Language_____ **Race** □White □Native American □African-American **Ethnicity** □Hispanic/Latino

□Declined to Answer □Asian □Other_____ □Non-Hispanic/Latino

□Declined to Answer □Declined to Answer

Person Responsible for Payment

****If patient is a minor or someone else is responsible for payment other than the patient, Please fill out the following.****

Name: _____ **Phone Number:**_____

Address (If different): _____ _____

Date of Birth:_____ **Social Security #:**_____

Primary Insurance Name: ID # Group #
Secondary Insurance Name: ID # Group #

I understand that office visit charges are payable on the day service is rendered. I authorize, Albuquerque Dermatology, to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Albuquerque Dermatology and myself. I understand that this policy will remain in effect for all services provided until I am notified of any change by Albuquerque Dermatology.

I understand that according to my insurance carrier contract, there may be co-pays and/or deductibles in addition to co-insurance amount that will be payable during the time that services are rendered. I understand that Albuquerque, Dermatology Associates and Cutaneous Surgery Center, PA have no knowledge of prepaid deductible amounts. I have been informed that Albuquerque Dermatology Associates and Cutaneous Surgery Center, PA can provide me with an **estimate** of my deductible liability at the time of my visit. I understand that these charges under the deductible owed may be significant.

In addition I have been informed of and given a copy of ADA's HIPAA private policy information brochure.

Signature _____ **Date** _____

Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient.

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing.

Spouse: _____ _____ yes _____ no

Parent: _____ _____ yes _____ no

Other: _____ _____ yes _____ no

_____ _____ yes _____ no

_____ _____ yes _____ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

_____

PRINTED NAME _____

Relationship to Patient _____

Patient/Parent/Guardian Signature: _____

Date: _____ Witness _____

Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA
WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA. I hereby acknowledge receipt of Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA's Summary of Privacy Practices and Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Albuquerque Dermatology Associates and Cutaneous Surgery Center, PA's Summary of Privacy Practices and Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

Signature :_____

Relationship to Patient (if other than patient):_____

Date:_____ / /

In front of _____
Printed name – Practice representative

MEDICAL HISTORY

This is a confidential part of your treatment and will be kept in this office. Information included on this form will not be released to anyone without written authorization from you.

DATE:_____ **NAME:** _____
(Last) (First) (Mi)

DOB: _____**BIRTHPLACE (city & state)** _____**Years in NM:**_____

Date of your last physical exam:_____**Occupation:**_____

Name of Primary Care Physician or Referring Physician _____

PERSONAL HISTORY OF ILLNESS (circle all that apply)

Acne
ADD/ADHD
Alopecia
Anemia
Arthritis
Atrial Fibrillation (fast, irregular heart beat)
Bleeding Disorders _____
Cerebral Palsy
Crohn's Disease/Ulcerative Colitis
Deep venous thrombosis (blood clot of the leg)
Diabetes Mellitus
Eczema
Gout
Headaches
Hepatitis Type:_____
Hypertension
Hypothyroidism (low)
Lymphoma/Leukemia Type: _____
Migraines
Parkinson's Disease
Psoriasis
Seizures/Epilepsy
Skin Cancer (Melanoma, Basal Cell Carcinoma, Squamous Cell Carcinoma, Basosquamous Cell Carcinoma)
Other Skin Diseases Type: _____
Sleep Apnea Use of CPAP device? Y N
Tuberculosis
Varicella Zoster (Chicken Pox/Shingles)
Vitiligo

Acid Reflux (GERD)
AIDS/HIV
Alzheimer's Disease
Anxiety
Asthma
Autoimmune diseases (Lupus, Scleroderma)_____
Cancer Type: _____
Congestive Heart Failure (CHF)
Chronic Obstructive Pulmonary Disease (COPD)/Emphysema
Depression
Diverticulitis
Glaucoma
Hayfever/Seasonal Allergies
Heart Disease/Heart Attack (myocardial infarction)
Hypercholesterolemia (high)
Hyperthyroidism (high)
Irritable Bowel Syndrome (IBS)
Measles
Multiple sclerosis
Pulmonary Embolus (blood clot of the lung)
Scarlet Fever
Sinus Problems
Stroke (TIA)
Syphilis
Ulcers Where? _____
Vertigo
Warts Where? _____

Are you currently pregnant? Y N Date of last pregnancy:_____

Have you had the influenza (flu) vaccination within the past year? **Y** **N**

Have you had the pneumococcal (pneumonia) vaccination within the past five years? **Y** **N**

Are you currently under the care of a psychiatrist? Y N If so, who is the doctor? _____

Which smoking status applies to you?

□ Never smoker

□ Former tobacco smoker When did you quit? _____

□ Current tobacco smoker How much: _____

□ Cigar smoker How much: _____

Do you drink alcohol? Y N If yes, how many drinks do you have per day? _____< 1 _____ 1 to 2 ____ 3 or more

How many times in the past year have you had 5 or more drinks in a day (men) or 4 or more drinks in a day (women)?_____

PAST SURGERIES (including history of pacemaker/defibrillator)
Please list what kind and date:

_____

PLEASE LIST ALL CURRENT MEDICATIONS (including prescription, over-the-counter and herbal medications)
Please list name, dosage and how the medication is administered.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Name and phone number of your preferred pharmacy? _____

Do you require the use of coumadin (warfarin), aspirin, Plavix (clopidogrel), Pradaxa (dabigatran etexilate) or Xarelto (Rivaroxaban)? If yes, please circle.

PLEASE LIST ANY DRUG ALLERGIES

_____

FAMILY HISTORY OF ILLNESSES (not the patient)

Have any of your first degree relatives (mother, father, siblings, children) had a history of the following:
If yes, please state which relative (not the patient).

Melanoma _____ Autoimmune diseases (Lupus, Scleroderma) _____

Skin Cancer (Basal Cell Carcinoma, Squamous Cell Carcinoma, Basosquamous Cell Carcinoma) _____

Hay fever _____ Eczema _____ Asthma_____Acne_____ Psoriasis_____

Other, please explain:_____

ALBUQUERQUE DERMATOLOGY ASSOCIATES & CUTANEOUS SURGERY CENTER, P.A.

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Pathology Policy

Dear Patients:

For all patients who will be having a **BIOPSY** done, there is an **ADDITIONAL** pathology fee of $208.71 to process the tissue from the biopsy in our facility. **Patients with insurance:** Some insurance plans are now charging co-pays, coinsurance and deductibles for your pathology charges, which will be billed to you after your insurance processes your claim. **For self-pay patients:** Pathology charges will be added to your bill. The front desk will give you the total charges including a minimum charge of $159.49 for your biopsy and $208.71 for the pathology with further charges for any additional procedures that are done.

Sometimes, an initial review of your biopsy indicates that further, more in-depth testing will be required to reach the correct diagnosis. In this case, supplementary charges ranging from $140.00 to $1,000.00 (in rare circumstances) will be assessed. You are responsible for any charges that are not covered by your insurance company.

There has been some confusion among our patients regarding charges for pathology. We hope we have provided proper information to our patients regarding charges incurred for these services. If you have any questions, please let us know.

Sincerely,

The physicians and staff at Albuquerque Dermatology Associates & Cutaneous Surgery Center, P.A.

_____

Patient Signature (or Parent's Signature if Minor)

I understand that the above pathology policy will remain in effect for all services provided until I am notified of any change by Albuquerque Dermatology Associates.

_____ _____

Patient Signature (or Parent's Signature if Minor) **Date**

General Financial Policy

I have received Albuquerque Dermatology's General Financial Policy. I understand that charges not covered by my insurance (pathology, office visits, additional surgical and non-surgical procedures), as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Albuquerque Dermatology Associates and I authorize them to release any pertinent medical information to facilitate payment of a claim. I understand that this policy will remain in effect for all services provided until I am notified of any change by Albuquerque Dermatology Associates.

_____ _____

Patient Signature (or Parent's Signature if Minor) **Date**

Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA
SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Date of Last Revision: 09/18/2013
Effective Date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our controller. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI. This notice is effective as of 09/18/2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer in writing for more information.

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BRIAN L. COSTELLO, MPAS, PA-C

Albuquerque Dermatology Associates & Cutaneous Surgery Center, P.A. Financial Policies

Thank you for choosing our practice! We are committed to the success of your medical care. Please understand that payment of your bill is part of this care. To help avoid misunderstandings, our financial policy is in writing. For your convenience, we have answered some commonly asked questions below. I understand that this policy will remain in effect for all services provided until I am notified of any change by Albuquerque Dermatology Associates and Cutaneous Surgery Center, P.A.

How may I pay?

We accept payment by cash, check, money order and gift certificate or by American Express, Discover, VISA or MasterCard

What if my child needs to see the physician?

A parent or legal guardian must accompany patients who are minors on the patient's first visit, and must sign the financial statement for the patient, accepting responsibility for the account. A parent must accompany children to all visits. A minor who is able to come by themselves must have permission in writing from a parent or legal guardian to have treatment in our clinic. The legal guardian or parent must also be available by phone for questions and consent to treat. A minor is considered anyone under the age of 18. Anyone above the age of 18 is financially responsible for any payment due our office.

What is your policy regarding missed appointments?

Patients who do not show up for an appointment, and do not call to cancel have impacted other patients' ability to obtain timely medical care. Therefore, subject to the individual patient's insurance contract, we reserve the right to charge for missed appointments.

Do copays need to be paid at the time of my appointment?

Yes. According to your contract with your insurance company, all copays are to be paid at the time of service.

What if my check bounces?

If a check is returned for insufficient funds, of if payment has been stopped, you will be charged a $25 fee in addition to the amount of the check. If you have a second check returned, you may be asked to pay by cash, money order or cashier's check, or credit card.

What if I do not pay my bill?

Accounts that are repeatedly ignored may be sent to collections. If this happens, you may have your credit adversely affected, and you will be dismissed from the practice and asked to find a new physician.

What is my financial responsibility for services?

This depends on a variety of factors and we suggest you call your insurance. If our office in not contracted with your insurance plan, we do not accept any allowables and you will be responsible for any amounts owed to our practice.

How am I to pay my part after you bill the insurance?

Once we receive the Explanation of Benefits from your insurance company, we will bill you for the balance that you owe. That amount is due upon your receipt of the statement. If we need to resend a statement, you may be charged a $1.50 rebilling fee.

What about "Non-medically necessary" procedures?

If you and your physician decide on a procedure that is not medically necessary (usually cosmetic procedures such as moles, spider veins, or skin tags), you will be asked to pay the estimated cost of the procedure prior to the procedure being done. You will then be balance-billed or refunded the difference. We will give you the information to file a claim on your own.

Can I just pay my balance by credit card?

Yes. We now offer the convenience of paying your coinsurance (your share after the insurance has paid) via credit card with our Easy Pay Option. To do this, you simply have to fill out a brief authorization form. Once your insurance has paid, your card will be charged the "patient due" portion. No bills to bother with! Just ask for an authorization form.

Your Responsibilities for Office Visits and Office Services

Commercial Insurance

Also known as indemnity or "80%/20% or 90%/10% coverage."Payment of the expected patient responsibility for all office visits, injections, and other charges at the time of office visit.

We suggest that you call your insurance company ahead of time to determine deductibles and coinsurance.

We will file an insurance claim as a courtesy to you only if payment in full is made for the date of service for all non-cosmetic claims.

HMO & PPO plans with which we have a contract

If the services you receive are covered by the plan: All applicable copays and deductibles are requested at the time of the office visit. If the services you receive are not covered by the plan: Payment in full is requested at the time of the visit.

We suggest that you call your insurance company ahead of time to determine copays, deductibles, and non-covered services for you. If your plan requires a referral and our office does not have a referral on file for you at the time of your visit, you will be required to reschedule for all services and treatments.

HMO with which we are not contracted, or Medicare HMO

Payment in full for office visits, injections, and other charges at the time of office visit. (We will provide the necessary information for you to file your claim directly with the insurance company.)

Point of Service (POS) Plan or Out Of Network PPO

Payment of the patient responsibility-deductible, copay, non-covered services-at the time of the visit. We suggest that you call your insurance company ahead of time to determine benefits, copays, deductibles, and non-covered services.

Medicare

If you have Regular Medicare, and have not met your $162 deductible, we ask that it be paid at the time of service. Any services not covered by Medicare are requested at the time of the visit. If you have Medicare as primary, and also have secondary insurance (Medigap): No payment is necessary at the time of the visit. If you have Medicare as primary, but no secondary insurance: Payment of your 20% copay is requested at the time of the visit.

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BRIAN L. COSTELLO, MPAS, PA-C

No Insurance/Worker's Compensation Insurance

Payment in full at the time of the visit. If the total cost of the visit is not able to be determined, you will be asked to make an estimated payment and will be billed or credited the difference. We will work with you to settle your account. Please ask to speak with our staff if you need assistance or regarding an extended payment schedule. Our office does not take worker's compensation insurance. You will have be required to pay your balance at the time of service.

Cosmetic Procedures

All cosmetic consult charges are due at the time of services. This charge for a cosmetic consult can range from $101.85 to $276.78. A hair removal consult charge is $53.50. All cosmetic treatments require payment in advance. Each cosmetic need can be charged a separate and distinct cosmetic consult charge. Due to the high expense of the professional supplies, equipment, and the extent of the appointment, prior payment is always required (no free consults will be given). All new cosmetic procedures require a cosmetic consult with a provider. Advance notice of cancellation is required. If you fail to show up for your cosmetic procedure or do not provide 24 hour notice of a cancellation, partial or full cost of the procedure will be assessed.

Scheduling

Certain procedures in our office require special, advanced planning and scheduling with the providers. Therefore, you may not be able to be scheduled with the provider at the time of your call. However, the person specific to your needs will call you back at his or her earliest convenience.

*This is only meant as a guide. Please check with your insurance company for more details.

Spa Services and Procedures

All spa services and procedures require payment at the time of service. We want to dedicate the proper amount of time to each patient's needs, therefore a patient is required to check-in ten minutes before their appointment. Any patients that are five minutes late will be rescheduled. Special order spa products require payment in advance. In order to provide you with a tranquil and relaxing environment, no children are allowed in the spa room and must be accompanied by an adult in our waiting lounge.

Please feel free to contact our billing department or office manager should you have any questions regarding this financial policy.
505-872-4700

Statement of Patients' Rights

Patients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Have their Private Health Information kept private. Only where permitted by law, may records be released without patient permission.
- Know of their rights and responsibilities in the treatment process..
- Know about their treatment choices. This is regardless of cost or coverage by the patient's benefit plan.
- Share in developing their plan of care.
- A clear explanation of their condition and treatment options.
- Information about ADA/CSC, its practitioners, and services.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Freely file a complaint or appeal.
- Know about advocacy and community groups and prevention services.

Statement of Patients' Responsibilities

Patients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the patient and provider.
- Comply the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including exact dosages, frequency of use and reason for use as well as medications given to them by others.
- Keep their appointments. Patients should cancel appointments 24-48 hours before scheduled appointment or as soon as they know they need to cancel.
- Let their provider know when the treatment plan isn't working for them.
- Let the billing office know about problems with paying fees.
- Report abuse and fraud.