Capital Family Practice
Kathleen M. Curtis, M.D., P.C.
Board Certified Family Practice
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Statement Of responsibility

To: Our Patients

From: Kathleen M. Curtis, M.D.

If you are now or become a member of any health care plan, you are bound by your health care plan to follow their rules. It is your responsibility to know what your health plan will cover and where, and to abide by their rules regarding care in our office as well as referrals, etc.,. It is impossible for our staff to be familiar with the separate requirements of your individual or group health plan as they can vary widely within the same HMO/PPO. If you have questions about what your health plan will and will not cover, you must contact them directly. Failure to provide us with your current healthcare card **prior** to being seen may result in your receiving a bill for the services provided. Co-payments must be made prior to each visit. If you have an HMO, it is your responsibility to contact your health care plan to change the designated Primary Care Physician (PCP) to Capital Family Practice. If it is determined that you need to see a specialist, it is your responsibility to obtain the referral and to keep track of expiration dates and number of visits authorized. Aetna referrals are done telephonically. We do not fax or mail Aetna referrals as paper referrals do not exist for Aetna. Please note that it takes **3 working days** to generate a referral and referrals can not and will not be dated retroactively. If you request services that are not covered by your insurance, **you** will be responsible for full payment.

If you cannot keep an appointment, we require 24 hours cancellation notice. Should you fail to do so you will be billed for the full amount of the office visit.

I hereby acknowledge that I have read and understand the requirement as stated above. I acknowledge that I will be financially responsible for any charge if the above conditions are not met. I am aware that if payments is not made and either I or my family is sent to collections, it is the policy of this office to discharge both me and my family from the practice.

Signature of Patient or Guardian:_____

Date:_____