Complete Care Family Medicine

Dr. Marcela Dominguez & Dr. Cheryl Thomas

Your Part…….12/2013

Our approach here at CCFM is based upon a partnership. Your commitment to participating in your personal health care program is essential and we look forward to that relationship.

Because we schedule extended time with each patient, ***cancellations must be made 24 Hrs before appointment time****.* ***A valid credit card number will be required*** *when making your appointment and will be charged the following fees.*
Cancellation fees are as follows:
$75 cancellation fee for first appointment
$25 cancellation fee for 30 minute follow up appointments
$50 cancellation fee for 45-60 minute follow up appointments

• Lab testing (labs done in-home or at our office) may not be covered by your insurance. This is a benefit that you will want to discuss with your insurance provider. In addition, a $25-$30 draw fee will apply for labs drawn in the office that will be the patient's responsibility.
• In some cases, patients are referred to collaborating physicians. While CCFM will make reasonable efforts to determine if collaborating physicians accept your insurance the final responsibility for that determination is yours.

CCFM does not base treatment recommendations on coverage. Traditionally insurance would be billed for all services rendered. However with recent changes in insurance plans we will be making the following adjustments, effective immediately. As your insurance may or may not cover the entire visit it will be the patient's responsibility to be clear about their insurance benefits. Patients will be expected to pay for all non-covered services when services are rendered. Please consult your Insurance provider before making your appointment or moving forward with specialty labs or testing. For "covered" benefits, we will bill your insurance. Once we receive the explanation of benefits from your insurance provider, ***your credit card on file will be charged the remaining patient balance dictated by your insurance.***

Please read, sign and return to the front desk.

Date___/___/_____

*Print Patient's name*_____

*Patient's Signature*_____