Stoneybrook Family Medicine Group
16106 Marsh Road, Suite 102
Winter Garden, FL 34787
p 407.347.0600
f 407.347.0599

Patient Contract

- I understand that I am responsible for notifying Stoneybrook Family Medicine Group's office of any changes in personal or insurance information as promptly as possible. _____ (INITIAL)
- I understand that I am responsible for payment/re-filing of all services filed to the incorrect insurance company due to my failure to notify the practice of changes in insurance coverage. _____ (INITIAL)
- I understand that I am responsible for the payment of all co-payment, co-insurance and deductible amounts at the time of service unless other payment arrangements have been made in advance. _____ (INITIAL)
- I understand that I will be charged and I agree to pay a $25.00 no show fee for any appointment missed without notice of cancellation (a 24-hour notice is appreciated). _____ (INITIAL)
- I understand that I will be charged and I agree to pay a $50.00 no show fee for any procedure appointment missed without notice of cancellation (a 24-hour notice is appreciated). _____ (INITIAL)
- I understand that three or more missed appointments will result in both the no show fees and possible dismissal from the practice. _____ (INITIAL)
- I understand and agree to pay a $10.00 fee **per prescription** to re-issue lost prescriptions. _____ (INITIAL)
- I understand and agree to pay a $32.00 returned check fee for any check denied for payment by my bank. I further understand that I will lose check-writing privileges at Stoneybrook Family Medicine Group once a check is denied for payment. _____ (INITIAL)
- If required by my insurance, I understand that it is my responsibility to choose a physician at Stoneybrook Family Medicine Group as my primary care physician (PCP). If I do not select a PCP, I understand that I may be financially responsible for all charges denied payment due to my negligence in notifying the insurance company of my choice. _____ (INITIAL)
- I understand that Summerport Family Medicine **does not** process RETRO-AUTHORIZATIONS for HMO insurance policies. I understand that it is my responsibility to know the requirements of my insurance policy and notify Stoneybrook Family Medicine Group **72 hours PRIOR** to any appointments/procedures requiring a referral or pre-certification. _____ (INITIAL)
- I understand that Stoneybrook Family Medicine Group does not process prescription requests on weekends or after office hours on weekdays. I understand and agree to pay a $25.00 unnecessary call fee for any calls or pages received by the doctor from the answering service after hours and on weekends for prescription requests. _____ (INITIAL)
- I understand that Stoneybrook Family Medicine Group processes prescription requests as quickly as possible. I understand that it is my responsibility to have my pharmacy request prescription refills via fax 72 hours prior to the expected pick up time for prescriptions. _____ (INITIAL)
- I understand that I am responsible and agree to pay all collection and attorney's fees resulting from my failure to pay any outstanding balances in a timely manner. _____ (INITIAL)
- I understand and agree that I will be charged a fee of $25.00 for any FMLA, Disability or any other paperwork.

I have read and understand the above contract and agree to abide by the policies outlined above.

Signature: _____ Date: _____