KENNETH T. KAAN, M.D., Inc. OFFICE POLICIES

Effective January 2013 our office has adopted new policies. These policies have been put into effect to clarify and outline various questionable areas. Please take a few moments to read this carefully before signing the bottom.

"NO SHOW/CANCELLATION POLICY"

1. We require a **24-hour** notice to cancel an appointment. If we do not hear from you within **24-hours** or if you miss your scheduled appointment, then we will consider it a "**NO SHOW**."
   If you are late for your appointment whether you call or show up late you will be considered a **"NO SHOW"**. You may reschedule to another day or wait to be worked in.
2. We will charge you directly for a "**NO SHOW**" appointment at a rate of **$25.00** per visit, which will be due prior to your next appointment. Your insurance will not pay for your missed appointments.
3. We require a **2-week** notice to cancel or reschedule any type of surgery. If you cancel or reschedule within **48 hours (2 business days - i.e. if you have surgery on Monday and you cancel on Thursday or Friday prior you will be charged)** from the day of surgery we will charge you directly a rate of **$250.00**. Your insurance will not pay for your surgery cancellation.
4. If you do not make any attempt to resolve your "**NO SHOW**" or **"CONSISTANT RESCHEDULING"** visits or if you repeatedly "**NO SHOW**", you will leave us no other alternative but to make other arrangements for your further treatments with another physician or health care facility, depending upon the individual circumstances.
5. For **MEDICAID & QUEST PATIENTS ONLY** in order to give *patients with serious medical problems* an opportunity for an appointment. We require a **minimum 24 hours** notice prior to your scheduled appointment for cancellations. Your appointment will be considered a **"NO SHOW"** if you miss your scheduled appointment without providing us with the **minimum 24 hours** notice. After three **"NO SHOW"** appointments our office may make alternative arrangements for your further treatment.

"FORMS POLICY"

1. **All** forms which need Dr. Kaan's signature only will be available for pick up every Tuesday after it is submitted. There is no charge for signature only.
2. **All** forms, which need to be filled out, will be charged at a rate of **$10.00(CASH ONLY)** *per form payable at the time of release*. Each form will be handled as a separate item and will be worked on in the order that it is received. If you have any form that needs immediate attention please let the Medical Assistant know and we will make every effort to put a **RUSH** on it. These forms will be available for pick up every Wednesday after it is submitted.

“MEDICAL RECORDS REQUEST”

1. Anyone requesting copies of medical records must have an authorization of release signed before any records are released.
2. We also charge **$25.00** for processing, printing, prepping, and shipping (if applicable). Plus **$1.00** per page printed and additional shipping charges if the record exceeds more than **25** pages.

“CO-PAYMENT POLICY”

1. All co-payments are due prior to being seen by Dr. Kaan. If you have the following insurance’s, you will have a co-pay. If you do not know your coverage type, please ask the front desk personnel.
2. If you are unable to make your co-payments at the time of your visit, please let the front desk attendant know so that a note can be posted into your chart.

“BALANCE DUE POLICY”

1. To cut down on the cost of mailing out a monthly statement, you will have the option to pay your current balances at the time of your office visit. We will ask you if you would like to receive your balance at the beginning of your scheduled appointment so you can determine if you would like to pay.
2. We accept Cash, Checks, Money Orders, Travelers Checks, VISA and MC as forms of payments.

“NO INSURANCE POLICY”

1. If your insurance is pending, we will ask for a CASH deposit in good faith. Your deposit will vary depending on the situation. You will be notified prior to your appointment how much of a deposit we will require before your office visit.
2. You will also be asked to sign a “Promissory Note”.
3. You must follow all instructions on the Promissory Note to ensure the return of your deposit. If you fail to notify us or follow the instructions on the Promissory Note you will forfeit your deposit and will be responsible for payment in full for any outstanding balances.

I, _____ understand and agree to comply with the above guidelines.

(Print patient’s/guardian’s name)

_____ _____

Signature (Patient/Parent/Guardian) **Date**

REVISED 08/15/14