FAMILY MEDICINE ASSOCIATES
OF NORTH STAFFORD

Office Policies

- Copays: If a copay is required by the patient's insurance, it will be due at the time of service.
- Late Arrivals: Patients who arrive past the appointment time may be asked to reschedule the appointment to a different time, or day.
- Appointments: Our office requires a 24-hour notice in the event a patient is unable to keep an appointment. Patients who cancel same day, or within 24 hours of an appointment may be subject to a cancellation fee.
    - Family Medicine Associates of North Stafford contracts and pays for an interpreter for hearing impaired and foreign language patients. In the event an appointment needs to be cancelled, it is the patient's responsibility to do so within 24 hours to avoid a $150 cancellation charge.
- No Call/No Show: $50
- Form Fees: The cost is variable due to its complexity and subject matter. Please discuss any form you have at the time of your appointment.
- Prescriptons:
    - Bring either all current medications in the original bottles, or a complete list of the medications including strength and dosage to all appointments.
    - Remember to closely track your number of refills available. It is patient's responsibility to monitor prescription refills and to ensure follow up appointments are scheduled in a timely manner.
    - Refills of any current medications will only be authorized during office hours. Our office requires a 24-72 hour notice for all medication refills.
    - Patients must make an appointment for ALL new prescriptions.
    - We do not accept pharmacy refill request.
- Cell Phone Usage In the Office: We kindly request that cell phone use be limited to the reception area. Phone calls should not be made or taken once in the examination room.

- Procedures: Patients with scheduled procedures should refrain from bringing children. We cannot be held responsible for children left unattended.

By signing below, the patient agrees to allow the provider/Family Medicine Associates of North Stafford to access the Data Center for Prescription Monitoring for the Virginia Prescriptions Monitoring Program.

I have read the above instructions and understand my responsibilities regarding my healthcare.

Patient Name: _____ Patient Date of Birth:_____

Patient/Guardian Signature: _____

Date: _____