About Our Practice

Norwich Medical Associates
12 Case Street, Suite 103
Norwich, Connecticut 06360
860-889-0147

Date: ____
Patient Name: _________________________________

Thank you for choosing **Norwich Medical Associates, LLC** as your primary care provider.

We are committed to overall wellness. Our behavior and the commitment of the integrity of clinical decisions making will be guided by the following general principles.

- Respect of client rights and dignity
- Privacy of the client and family and confidentiality of all patient information
- Practice of a uniform standard of care and conduct throughout the office

We will provide care only to those for whom we can care for safely in the office and will arrange for treatment elsewhere for those whom we cannot. This office will provide twenty-four hour on call service for emergencies.

New patients: You will be asked to **call** the office for your initial visit so that we may enter all of your information into registration system. You will be asked to bring in insurance cards, a photo ID along with a list of current medications to your first visit. *It is your responsibility to call your insurance company to verify coverage with our practice*.

Co-pays are due at the time of visit.

Appointments: Patients are seen by appointment except in the case of return blood pressure checks, routine injections and INR's. We expect that you will be present at all scheduled appointments. If you need to cancel an appointment please be sure to give us a 24 hour notice. We reserve the right to charge a $25 fee for visits cancelled less than 24 hours and for missed appointments.

Prescription Renewals: Medications are an important part of your treatment; therefore, we ask that when you need a renewal you call ahead to allow 72 hours for processing your request. Prescription refills depend on periodic testing, your refills will be completed after the test results are received.

Test results: It takes time to receive the test results, have the physician review them and relay the information to you. Please allow one week for this information. If you are registered in our patient portal your results will be available to you in the secure portal. If after two weeks you have not received your test results, you may call the office for the results.

Self-pay Patients: We do not accept *new* patients without insurance. If you lose your insurance while a patient of our practice you will be require to pay a $100 deposit for an office visit. Any remaining balance is due within 30 days. Future appointments will not be made until the balance is paid. Failure to pay may result in discharge from the practice.

Payment of your bill: Your copay, coinsurance or deductible are considered part your responsibility and a clear understanding of our financial policy is important to our professional relationship. It is also

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important that you are aware of and responsible for, your own insurance benefits. When in doubt, contact your insurance company directly for clarification. You are responsible for care not covered by your insurance plan.

Co-pays are due at time of visit if you cannot make your co-pay you may be asked to reschedule your appointment. Any balances are due within 30 days. If your balance is not paid within 60 days the account is considered for collection. Patients who are unwilling to adhere to these basic requirements will not be able to schedule an appointment and may face discharge from the practice. Returned check will be assessed a $25.00 fee.

Workers compensation/ Automobile Accidents: In order to submit medical bills accurately, we will require the following information before the visit: Date of injury, claim number, insurance company's address, phone number and the adjuster's name. If the workers' compensation claim is denied and you have private health insurance, they may be billed. If your workers' compensation or accident coverage does not pay you ARE responsible for payment.

I acknowledge that I have read and understand the information contained in this document. I understand that I may request a copy of this notice.

Patient Name____ Date of Birth: ____________________

Signature: ____ Date: ___________________________

Reason Patient is unable to sign: _________________________ Relationship to patient: _____________