GREEN MOUNTAIN PARTNERS FOR HEALTH
Patient Responsibilities

Name of Patient: _____ Patient Date of Birth: _____

___ Notify your health insurance company of your new primary care provider, if required.

___ Specific concerns or medication refills may require an office visit separate of a wellness exam of physical.

___ If you have specific issues addressed during your wellness exam or physical you will likely have additional charges.

___ Bring government issued photo identification and insurance cards to every visit.

___ Contact the office if you're delayed more than 10 minutes as we may need to reschedule.

___ Cancel any appointments at 24 hours in advance. Cancellations with less than 24 hours notice will count as a “no show”.

___ If you “no show” more than twice you may be asked to find a new doctor's office.

___ It is your responsibility to know if you have any special requirements from your insurance in regards to referrals or other care and to understand the cost of all services provided.

___ Co-payments you will owe, according to your insurance, are due at your appointment.

___ If you have a balance due you may be asked to pay a portion of that balance before you can be seen.

___ If you are “self pay” (without insurance) you will be asked to pay for your visit at the time of service. You will receive a 30% discount for paying at the time of service.

___ Refills must be requested through your pharmacy and if you are out of medication it probably means you are due for another appointment.

___ You must be seen to get refills of controlled substances. These cannot be filled more than 90 days at a time.

___ Payment for service with large deductible plans is due at the time of the appointment.

___ Insurance Authorization and Assignment of Benefits
I hereby authorize payment directly to Green Mountain Partners for Health, PLLC and authorize release of any medical information necessary to process insurance claims and for utilization review and quality assurance. I voluntarily consent to treatment for myself and/or dependents. I understand that I am financially responsible for all charges not covered or billed to any insurance or third party payor and/or not paid to Green Mountain Partners for Health. Should the account be turned over to collections, I will pay all costs of collection including, but not limited to, agency fees, attorney fees and court costs. I further understand that a monthly finance charge of 1.5% (18.00% annually) will be assessed on any unpaid balance.

PATIENT/GUARDIAN SIGNATURE: _____ Date: _____
(If patient is a minor, parent/legal guardian must sign on their behalf)