Donna Johnston, MD
8061 Spyglass Hill Rd. suite 102
Melbourne, FL 32940
321-751-7041

Patient responsibilities: Please initial after reading each statement.

All patients are responsible for re-scheduling any cancelled appointments, especially those to review tests that were performed.
There is a fee for "NO SHOW" (not showing up to an appointment without calling).
There is a fee for showing up late for your appointment.
INITIAL: _____

All patients are responsible to know the details of their insurance, including: coverage, participating labs, diagnostic imaging centers, specialists, and hospitals. Please read and be familiar with the details of your insurance policy as every policy is different.
INITIAL: _____

I assign all medical benefits to which I am entitled to Dr. Donna Johnston for services rendered. A photocopy of this assignment is to be considered as valid as the original. This assignment will remain in effect until revoked by me in writing. **I understand that I am ultimately financially responsible for ALL CHARGES whether or not approved or paid by my insurance company.** I also authorize the release of any information/medical records regarding my treatment to my insurance company to help secure for services rendered and to any of my health care providers. I understand that any **Co-Payments, Balance Due, or DEDUCTIBLE will be due at the time of service.** I will not ask the staff to "bill me" for this.
INITIAL: _____

If this account is assigned to a collection agency, an additional fee of 40% of amount owed will be added. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to any and all attorney's fees and cost of collection.
INITIAL: _____

I am aware that it is my responsibility to determine if Dr. Donna Johnston is an "in-network provider" for my insurance plan. (Example: Dr. Johnston is a "BCBS provider" but that does not mean that every person with a BCBS plan can come here: there are some BCBS for which Dr. Johnston is NOT an in-network provider.)
INITIAL: _____

When changing insurance: It is my responsibility to provide Dr. Johnston with a copy of my New Health insurance card any time I change insurance. If I fail to do so and services are not paid due to submittance to the prior health insurance, I will be responsible for the bill.
INITIAL: _____

If choosing a new insurance company: please consider the PPO product as many HMO products have insufficient coverage, difficult referral processes, or don't cover tests in some cases. Always verify that Dr. Johnston is an "in-network provider" before committing to the new insurance plan.
INITIAL: _____

If you have purchased any "OBAMACARE" insurance product off of the Marketplace, please realize that if you stop paying your insurance premium but continue to see the doctor, **you will be responsible for paying the full amount of the bill.**
INITIAL: _____

When calling after hours, a message can be left that will be addressed as soon as possible by the staff. Please only use the doctor's pager for reasonable questions, not for scheduling an appointment or to cancel an appointment. Do not page the doctor asking for controlled substances and or for an antibiotic: These medications require an office visit to be prescribed. **No controlled substances or antibiotics will not be prescribed without an office visit.**
INITIAL: _____

Be aware that the doctor cannot examine and diagnose over the phone. Before paging the doctor, consider if it can wait until business hours and/or would a visit to an urgent care center be more appropriate. Evaluation to determine whether antibiotics are needed requires evaluation by a physician = office visit.
INITIAL: _____

Chronic conditions require an office visit every 3-6 months. Schedule your next appointment or at least mark your calendar. It is **your responsibility** to be aware when your next office visit will be. Your medication will not be refilled if you are overdue for your office visit. (Consider using your cell phone to set an alarm to remind you when your next office visit, labs, etc. are due.)
INITIAL:_____

Your yearly physical is separate from follow up visits for chronic medication conditions. Please do not try to combine the two as the time set for the physical is strictly for the physical. A separate appointment is needed to follow up every 6 months for your hypertension, high cholesterol, diabetes, hypothyroidism, or any other chronic condition being followed.
INITIAL: _____

If under 18, you need to be accompanied by a parent/guardian, or have parent/guardian sign a release allowing you to come on your own.
INITIAL: _____

Review your **EOB (explanation of benefits)** when it arrives in the mail from your insurance company: It will state, "This is not a bill" but it does break down what portion of your visit was paid by your insurance plan and **what portion is your responsibility.** The amount listed as your responsibility is how much you need to pay the doctor. Feel free to pay that amount at any time. Eventually my biller will send you a statement for that amount, but you do not have to wait for the statement to arrive: you can pay when your EOB arrives. Keep your EOB's in a file at home and bring to any office visit if you would like my staff to go over it with you.
INITIAL: _____

Do not disregard letters from your insurance company as un-important: sometimes they send you a questionnaire to fill out: at times this delays payment of your bill if you do not respond. This could result in you becoming responsible for full payment of the bill. Again, anything they send you that you have questions about bring to the office.
INITIAL: _____

Acknowledgment of receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided the Notice of Privacy Practices that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

Printed patient name: _____

Signature of patient or: _____ Date: _____
Legal representative

Witness: _____ Date: _____