

# SAN DIEGO COASTAL ENDOCRINOLOGY GROUP, a Medical Corp.

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## OFFICE POLICIES

Thank you for choosing us as your endocrinology specialists. Our goal is to provide you with superior healthcare. We have developed the following policies with the objective of preventing billing confusion and improving efficiency of patient care.

- **Contact Information:** It is your responsibility to provide us with a current address and telephone number. If you have any changes to your address or phone number, then you must contact our office. Please provide at least one phone number where we can leave a message.
- **Contracted Insurance Plans:** It is your responsibility to supply us with accurate and up to date insurance information. This includes a current and valid insurance card, photo identification, the correct insurance billing address, and any other information required by your insurance carrier for payment of the medical services provided to you. If you fail to provide our office with accurate, up-to-date insurance information, then you will be financially responsible for any medical services provided to you and not paid or approved by your insurance company.
- **Change of Insurance:** You must provide us with any change of insurance information one week prior to your next office visit. If you do not provide us with the change in insurance information in a timely manner, then you will be responsible for any medical services provided to you and not paid or approved by your insurance company. If necessary, your office visit will be cancelled or rescheduled.
- **Non-Contracted Insurance Plans:** Payment is expected at the time of service; however, we will bill your insurance company as a courtesy to you. If your insurance company pays for the service, then we will provide you with a refund.
- **Private Pay (Patients with no insurance coverage):** Payment is expected at the time of service. If you are unable to pay at the time of service, then your office visit will be cancelled or rescheduled.
- **Co-payments:** By Federal Law and Managed Care Contract Law, this office is required to collect co-payments for each encounter/office visit. Insurance co-pays are due and payable at the time of your office visit. There is a \$25 administrative charge if we bill you for unpaid co-pays.
- **Non-payment by insurance company:** If your insurance plan, insurance company, or medical group refuses to pay your account, then you will be

financially responsible for payment of charges for the medical services provided to you.

- **Returned Checks:** You will be required to pay cash for returned checks and **all additional costs charged by the bank**. Typically, the bank charges an additional \$25.00.
- **Reschedule or Cancel Office Visit:** If you need to reschedule or cancel an office visit to see our providers, then we request that you contact the office 24 hours in advance. We understand that unforeseen circumstances might make it impossible for you to contact our office 24 hours in advance; **however, if you miss office visits without rescheduling or canceling 24 hours in advance, then you will be dismissed from the practice and you will need to seek medical care from another physician.**
- **Medical Records:** Our office will copy your medical records upon receipt of a written authorization and payment of a copying fee. The medical records will be mailed to you within three weeks. Pickup of the medical records at the office is not available. A minimum \$15 fee will be charged for the copying of medical records. A higher fee may be charged for voluminous medical records.
- **Completion of Medical or Employment Disability Forms:** A fee may be charged for completing any medical or employment disability forms not involved in your continuing care
- **Telephone Calls:** During office hours, Monday thru Friday, 8:30am to 4:30pm, you can reach us at 619-691-0388 in Chula Vista and 858-704-4151 in Solana Beach.
- **For emergencies contact 911 regardless of the day or time. Do not leave emergency messages on the voice mail system.**
- **All urgent telephone messages will be returned immediately.** All other telephone messages will be returned as soon as possible or within 24 hrs. Please do not call multiple times for the same message, it will only tie up the phone lines and your messages will not be answered any faster.
- **Prescription Refills: We require 48 hours for refills.** All prescription refill requests must come directly from the pharmacy. The pharmacy should fax the prescription refill request to 619-691-0387 in Chula Vista and to 760-334-2006 in Solana Beach . If the pharmacy states that they have called us and that they are waiting on a call back for an approval from our office, then please ask them to refax the requests if it has been more than 48 hours
- **Laboratory/Radiology/Specialty Care:** Many insurance companies require that you use a specific laboratory, radiologist, or other contracted specialist. **It is your responsibility to determine which providers are contracted with your insurance plan or medical group.** We are not financially responsible if you go to a laboratory or other medical provider that is not contracted with your insurance plan or medical group. It is your responsibility to contact your

insurance plan or medical group to confirm covered services and covered providers.

- **On-Call Schedule:** Occasionally your doctor is called away from the office. Sometimes your doctor will arrange for another doctor to see you. We will make every effort to inform you in advance if this is necessary. Emergencies cannot be scheduled and we apologize for any inconvenience or delays this may cause. We appreciate your understanding.
- **Patient Care Policies:** Our goal is to offer you the very best medical care. We also value a comfortable and respectful office atmosphere. To achieve our goal of mutual respect among patients, physicians and staff, we ask that you comply with our policies.
- **Comments or Complaints:** Please address all comments or complaints regarding your contact with our office in writing. Include details such as date, time, name of staff, and the issue. Mail the comment or complaint to our office addressed to your physician.

**Patient's Name:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_