**NEW PATIENT INTAKE FORM (MEDICAL HISTORY)**

**Patient’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit**(Brief)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS: DO YOU HAVE/RECENTLY HAD ANY OF THE FOLLOWING:**

Skip if we have copied your list**. \_\_\_\_**Pain (Location: \_\_\_\_\_\_\_\_\_\_\_)

Name Dose \_\_\_\_Head \_\_\_\_Migraine

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Neck \_\_\_\_Stroke

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Low Back \_\_\_\_Seizure

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Arms/Hands \_\_\_\_Fainting/Blackouts

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Legs/Feet \_\_\_\_Multiple Sclerosis

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Abdomen (belly) \_\_\_\_Alzheimer’s Disease

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Chest \_\_\_\_Parkinson’s Disease

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Psychiatric Disorder

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Memory Loss/Confusion \_\_\_\_Depression

\_\_\_\_Right handed\_\_\_\_Left Handed \_\_\_\_Walking difficulty \_\_\_\_Meningitis

Cigarette Smoker?\_\_\_Yes\_\_\_\_No \_\_\_\_Dizziness \_\_\_\_Neuropathy

Alcohol? \_\_\_Yes\_\_\_\_No \_\_\_\_Double vision \_\_\_\_Carpal Tunnel Syndrome

If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Swallowing difficulty \_\_\_\_Muscle Disease

**FAMILY HISTORY: \_\_\_\_**Numbness **\_\_\_\_**Myasthenia Gravis

\_\_\_\_High Blood Pressure \_\_\_\_Weakness \_\_\_\_Lupus

\_\_\_\_Heart Disease \_\_\_\_Nausea/Vomiting \_\_\_\_ Scleroderma

\_\_\_\_Stroke \_\_\_\_Weight loss \_\_\_\_Cancer

\_\_\_\_Diabetes \_\_\_\_Muscle cramps Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Seizures \_\_\_\_Leg pain when walking \_\_\_\_Bleeding Disorder

\_\_\_\_Headaches \_\_\_\_Swollen glands \_\_\_\_Blood Clotting Disorder

\_\_\_\_Alzheimer’s Disease \_\_\_\_Hair loss \_\_\_\_Hypertension

\_\_\_\_Parkinson’s Disease \_\_\_\_Fatigue \_\_\_\_Diabetes

\_\_\_\_Multiple Sclerosis \_\_\_\_Sleeping difficulty \_\_\_\_Atrial Fibrillation

\_\_\_\_Neuropathy \_\_\_\_Hallucinations \_\_\_\_Arterial Blockage

\_\_\_\_Lupus \_\_\_\_Depression \_\_\_\_Heart Disease

**PRIOR SURGERY:** \_\_\_\_Cough \_\_\_\_Emphysema

\_\_\_\_Brain \_\_\_\_Shortness of breath \_\_\_\_Asthma

\_\_\_\_Heart \_\_\_\_Rash \_\_\_\_Ulcer Disease

\_\_\_\_Neck(spine) \_\_\_\_Skin condition \_\_\_\_Kidney Failure

\_\_\_\_Low Back(spine) \_\_\_\_Joint pain \_\_\_\_Thyroid Disease

\_\_\_\_Carpal Tunnel \_\_\_\_Urinary problems \_\_\_\_Liver Disease

\_\_\_\_Carotid \_\_\_\_Blood in stool \_\_\_\_Glaucoma

\_\_\_\_Vascular(blood vessels) \_\_\_\_Vision problem \_\_\_\_Arthritis

\_\_\_\_Stomach **ALLERGIES:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Hysterectomy **HAVE YOU HAD ANY OF THE FOLLOWING TESTS?**(circle if **YES**)

Last Menstrual Period\_\_\_\_\_\_\_\_ CT/MRI of Brain/Spine, Nerve Conduction/EMG, EEG/Evoke Potential,

Lumbar Puncture, Nerve/Muscle Biopsy.

(NOTICE: Since Dr. Koberda is not a primary care physician, we encourage every patient to select a primary care provider before scheduling an appointment with Dr. Koberda**.)**

**I consent to the release of my medical information from Dr. Koberda’s office to my primary care provider. Name of my physician is:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PATIENT LAST NAME, FIRST NAME, MI** | | | **PATIENT SOCIAL SECURITY #** | |
| **MAILING ADDRESS** | | **PATIENT’S HOME PHONE NUMBER**  **( )** | **DATE OF BIRTH** | **SEX (CIRCLE)**  F M |
| **CITY** | | **WORK PHONE NUMBER**  **( )** | **MARITAL STATUS (CIRCLE)**  SINGLE MARRIED DIVORCED WIDOWED | |
| **STATE** | **ZIPCODE** | **EMPLOYMENT (CIRCLE)** FULL TIME, PART TIME, RETIRED, DISABLED, UNEMPLOYED | **PATIENT RELATIONSHIP TO INSURED**  SELF, SPOUSE, CHILD, OTHER | |

**GUARANTOR INFORMATION (PARTY RESPONSIBLE FOR BALANCE OF BILL)**

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT LAST NAME, FIRST NAME, MI** | **HOME PHONE NUMBER**  **( )** | **WORK PHONE NUMBER**  **( )** | |
| **MAILING ADDRESS** | **CITY** | **STATE** | **ZIPCODE** |

**PRIMARY INSURANCE INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SUBSCRIBER LAST NAME, FIRST NAME, MI** | | | **SUBSCRIBER SOCIAL SECURITY #** | |
| **MAILING ADDRESS** | | **PATIENT’S HOME PHONE NUMBER**  **( )** | | **POLICY HOLDER’S DATE OF BIRTH** |
| **CITY** | | **WORK PHONE NUMBER**  **( )** | | **INSURED RELATIONSHIP TO PATIENT**  SELF, SPOUSE, CHILD, OTHER |
| **STATE** | **ZIPCODE** | **POLICY HOLDER’S EMPLOYER** | | **POLICY NUMBER**. |
| **PRIMARY INSURANCE NAME** | | | | **GROUP NUMBER** |

**SECONDARY INSURANCE INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SUBSCRIBER LAST NAME, FIRST NAME, MI** | | | **SUBSCRIBER SOCIAL SECURITY #** | |
| **MAILING ADDRESS** | | **PATIENT’S HOME PHONE NUMBER**  **( )** | | **POLICY HOLDER’S DATE OF BIRTH** |
| **CITY** | | **WORK PHONE NUMBER**  **( )** | | **INSURED RELATIONSHIP TO PATIENT**  SELF, SPOUSE, CHILD, OTHER |
| **STATE** | **ZIPCODE** | **POLICY HOLDER’S EMPLOYER** | | **POLICY NUMBER**. |
| **SECONDARY INSURANCE NAME** | | | | **GROUP NUMBER** |

**RELATED INSURANCE INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **IS THIS VISIT WORKER’S COMP RELATED? (CIRCLE) YES NO** | **IS THIS VISIT “NO FAULT” RELATED? (CIRCLE) YES NO** | | **IS THIS VISIT AUTO ACCIDENT RELATED? (CIRCLE) YES NO** |
| **REFERRING PHYSICIAN** | | **PRIMARY PHYSICIAN** | |

**PATIENT STATEMENT**

**I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, VERIFY THAT ALL OF THE ABOVE IMFORMATION IS ACCURATE.**

**(PRINT NAME)**

**SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization For Signature on File—Medicare and Other Insurances**

I request that payment of authorized Medicare or other Insurance Company benefits be made on my behalf to Dr. J. Lucas Koberda, M.D., PhD., Neurology, PL for any services furnished to by the physician/other party. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 112&B of Social Security Act and 31 U.S.C. 3801-3812 provide penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical and other information about me to be released to the Social Security Administration and Health Care Financing Administration, its intermediaries, carrier, and/or any other insurance company. I release any information needed for this or related Medicare/Other Insurance Company/related Medigap claim. I permit a copy of this authorization to be used in place of the original.

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL POLICY**

I hereby give my permission to Dr. Koberda to administer treatment, request: labs, MRIs, MRAs, CTs, testings, perform Nerve Conduction Studies and other testing as may be necessary in the diagnosis and/or treatment of my condition.  
  
This is an agreement between Dr. J. Lucas Koberda as creditor and the patient/debtor named on this form.  
  
In this agreement, the words “you,” “your,” and “yours” mean the patient/debtor. The word “account” means the account that has been established in your name to which charges are made and payments are credited. The words “we,” “us,” and “our” refer to Dr. J. Lucas Koberda.

By executing this agreement, you are agreeing to pay for all services that are received.  
  
Statements: If you have a balance on your account, we will send you a statement only ONCE.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable when the statement is issued and is past due if not paid within 10 days from the statement date.

Charges to account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: Insurance is a contract between you and your insurance company. We are not a party to this contract in some cases. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance might pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower payment from the insurance company or even lack of it.

Required payments: Any co-payments and co-insurances required by an insurance company must be paid at time of service. If co-payment or co-insurance is not paid at the time of the visit and we have to send you a statement, an administrative fee of $5.00 will be imposed to your account.

Returned checks: There is a fee of $25.00 for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collections agency, you agree to pay a collection cost fee. If we have to refer collection of a balance to a lawyer, you agree to pay all lawyer’s fees, which we incur, as well as all court costs.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment from our practice may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Transferring of records: You will need to request in writing and pay a reasonable copying fee (currently $1.00 per page plus shipping) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history.

Worker’s Compensation: If your case is denied, you will be responsible for payment in full.

Effective date: Once you have signed this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Responsible Party (if not patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEUROFEEDBACK CONSENT FORM**

Neurofeedback is an alternative form of therapy and not a covered service by most insurance companies. Patients who choose to use this form of therapy will be expected to self-pay at the time of service.

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**NEURO-PSYCHOLOGICAL TESTING CONSENT FORM**

NEUROTRAX is a neuro-psychological test and is not a covered service by insurance companies. Patients who choose to take this test will be expected to self-pay a fee of $75.00 at the time of service.

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**MEDICAL RECORDS RELEASE FORM**

**Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

You are hereby authorized to furnish Dr. J. Lucas Koberda, M.D., PhD, Neurology, PL with medical records from the following facility:

**Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facility Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that Dr. J. Lucas Koberda, M.D., PhD, Neurology, will treat all information as strictly confidential.

**Patient’s or Guardian’s Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s or Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received a copy of Dr. J. Lucas Koberda, M.D., PhD, Neurology, PL Notice of Privacy Practices with an effective date of September 1st, 2012.

**Name of Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address of Patient**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Witness**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby request confidential communication of protected health information.

**Designated Method of Contacting the Patient**

Communications with the patient named above should be directed to:

Mailing Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to leave voicemail: \_\_\_\_\_ YES \_\_\_\_\_ NO

**Patient’s Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CANCELLATION AND NO SHOW POLICY**

Due to the rising demand and steadily growing number of patients on our waiting list, we are forced to rectify issues with patients who **cancel scheduled appointments on short notice** or simply **do not show up at all**. When appointment times *chosen by patients* are made, those times are reserved specifically for them. We do not double book appointments, so we kindly appreciate the same respect in return.

Our scheduling policy as of **September 1, 2015** is as follows:

* If a patient wishes to cancel his or her appointment for ANY reason, he or she may call our office at (850) 877-2802 **NO LATER THAN 24 HOURS** prior to the appointment time. The patient may then make a new appointment over the phone.
* Voicemails left over the weekend **WILL NOT BE HONORED** for Monday appointments. If a patient wishes to cancel a Monday appointment, arrangements need to be made the Friday before between the hours of 8:00 AM and 12:00 PM.
* In the event that a patient cancels a scheduled appointment with less than 24 hours’ notice or fails to show up all together, the appointment will be marked as a **NO SHOW** in our system, a notification letter will be mailed to your home, and a **$25.00 administration fee** will be assessed to your account immediately.
* **If a patient cancels or no-shows to a total of THREE appointments, his or her chart will be closed and a letter notifying the patient of withdrawal from the practice will be mailed to your home.**

In order to preserve the satisfaction of our compliant patients, we are left with no option other than to resort to imposing a service fee on those who are noncompliant.

**With regards,**

**Dr. Koberda and staff.**

**Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**