Sonshine Family Health Clinic, LLC Policy and Financial Agreement

Please carefully read and initial each statement. I acknowledge and agree that if I fail to adhere to these policies I may be asked to leave, find a new provider, or be escorted off the premises by a peace officer.

1. **I understand that this office does NOT prescribe any controlled substances. We participate in the Prescription Monitoring Program administered by the Idaho Board of Pharmacy Prescription Monitoring Program.** The system collects prescription data on controlled substances dispenses in or into the state of Idaho. The program is mandated pursuant to Idaho Code 37-2730A. __________
2. I agree to pay for services in full at the time of service unless insurance eligibility has been verified**.** I may obtain a list of charges from the front desk. **I understand that this clinic does NOT make any payment arrangements. If I do not have insurance I will be given a discounted rate. If I do not pay for services in full at the time of service I will be charged the full insurance rates.** ________
3. I am required to cancel my appointment at least 1 business day prior to the scheduled appointment. Failure to give notice will result in a missed appointment or "no show". **I understand I will incur a $10.00 fee for the second (2nd) missed appointment and a $20.00 fee for the third (3rd) missed appointment.** I may be asked to find a new provider & will no longer be able to schedule appointments. Any further appointment needs will be on a strictly walk in basis during walk in hours. ______
4. If an appointment is not available I may walk in & wait to be seen during designated walk in hours. Walk-In hours are available Monday, Tuesday, and Wednesday 8:00am - 10:00am & 1:15pm - 3:00pm, Thursday 8am - 10:30am & 2:15pm - 4:00pm, Friday 8:00am – 10:00am. I understand no walk in appointments will be accepted after walk in hours have ended. ______
5. No cell phones are to be used in this office. I am to make or accept calls outside the office. ________
6. For refill I will call my pharmacy and have them send a request to my provider. Refill request take 24-48 hours to process. It is my responsibility to request them before I am out of medications. No refills will be given after office hours. I will not call the after hours emergency line for refill requests. _______
7. All requests for medical records must be in writing on a HIPPA compliant request. There is a $15.00 copy fee for this service. Medical records will be available within 5 business days. Payment must be made before my request will be processed. _______
8. If I request disability/FML/applications to be filled out or a letter written on my behalf that there is a fee for this service ranging from $10.00 to $30.00, depending on the length and complexity. All requests for letters require a minimum of 48 hours to complete. Forms and applications may require up to 5 business days to complete. Payment must be made before my request will be processed. ______

I have read, understood, and agree with all of the above listed policies. Please know that regardless of signature/initial on this page that all office policies will still be enforced.

________________________________ ____

Print patient name Signature of Patient/Parent/Guardian Date