Dr. Syed V. Ahmed M.D.
Westside Medical Clinic

DISCLOSURES AND WAIVERS

FINANCIAL POLICY

In order to provide a reasonable quality of healthcare it is very important for a practice to stay financially viable. **Payment is due at the time of service unless arrangements have been made in advance**. We accept cash, Visa, MasterCard, Discover and American Express. We reserve the right to accept checks for our established patients.

Upon your arrival, your benefits will be explained to you, to the best of our understanding. It is the responsibility of the patient to contact their insurance company for further clarification.

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY WESTSIDE MEDICAL CLINIC OF ANY CHANGES TO THE PATIENTS INSURANCE COVERAGE.

_____ Initials - **I understand the services rendered may not be covered by my health plan. If the insurance plan determines a service to be "not covered" I will be responsible for the complete charges. If it is later determined that my coverage was not active on the day of the service, I will be responsible for the charges.**

_____ Initials - **I authorize Westside Medical Clinic to store my credit card in a secure electronic format that is PCI-DSS compliant.**

Your health plan is a contract between you and your insurance company. Health plans vary widely as far as benefits are concerned and in some instances your responsibility may not be evident till we get a response from the insurance company. **You will be responsible for co-pay, co-insurance, and deductible and uncovered charges which ever apply to you**.

If you are unable to pay, please call the office for setting up a payment plan or an alternate arrangement. No response after repeated attempts to contact you will result in your case being referred to a collection agency.

_____ Initials - **A charge of $25 will apply for all returned checks, I have read and understand the Clinic's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the Clinic from time to time.**

APPOINTMENT POLICY

Our goal is to provide quality individualized medical care in a timely manner. "**No shows**" and **late cancellations** inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

No Show Policy
A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the medical record as a "no-show". Emergency cancellations are accepted only for illness, illness of a family member or death in the family.

Cancellation of an Appointment
In order to be respectful of the medical needs of other patients, please be courteous and call the office at 281-398-2900 promptly if you are unable to show up for an appointment. **After two consecutive cancellations, you may be charged for the third cancellation**, please keep in mind this time can be reallocated to someone who is in need of an appointment.
Please note we will attempt to call, text and/or email you, to confirm your appointment with us within a week of your appointment.

_____ Initials **Missed and/or cancelled appointments: There is a $80.00 charge after the first no show for office appointments and $120 for missed physical or wellness visits. The charge is not billable to insurance you will be responsible for payment out of pocket.**

TO CANCEL APPOINTMENTS, PLEASE CALL 281-398-2900 BETWEEN 8AM – 5PM
MESSAGES CAN BE LEFT ON VOICE MAIL, DO NOT EMAIL CANCELLATION REQUESTS.
PATIENTS CAN CANCEL AND REQUEST RESCHEDULED APPOINTMENTS THROUGH THE PATIENT PORTAL.

ALL CANCELLATIONS MUST BE 24 HOURS BEFORE THEIR SCHEDULED APPOINTMENT

PATIENT RESPONSIBILITY AGREEMENT FOR REFERRALS

_____ Initials - **I understand that if a referral or an authorized referral is required to schedule an appointment with any specialist I will notify Westside Medical Clinic with the name of the doctor where a referral will need to be faxed to, at least 3 business days before any scheduled appointment. Westside Medical Clinic is not responsible for providing a list of doctors who are in my network; the referral list or business cards I receive for referral's are to be used only as a reference.**

DECLARATION

I have read and understand the above agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement than the rendition of services. All of my questions have been fully answered

PRINT PATIENT NAME **DATE**

PATIENT SIGNATURE **PRINT PARENT/LEGAL GUARDIAN NAME**

(IF MINOR)