Dr. Randolph's Ageless & Wellness Medical Center

C.W. Randolph, Jr., M.D. ● Lori Leaseburge, M.D. ● Nicole Thomas, ARNP ● ● Steven Garces, ARNP ● Kristin Byers, ARNP ●

PRACTICE POLICIES

(Please Initial and Sign)

Name: _____ DOB: _____

Appointment 'No Show' and Cancellation Policy

_____ A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a 'no show." A $50.00 'no show' and cancellation fee will be issued for any appointment that is missed by the patient or not cancelled 24-hours prior to the appointment. Patients will receive an invoice in the mail.

Late Appointment Policy

_____ We recognize that unforeseen events may delay your arrival, however, please note that you are considered late if you arrive **10 minutes past** your scheduled appointment. If you should arrive late for your scheduled appointment, it is to the provider's discretion whether you are worked back into the schedule (prioritize among those patients who arrived on time) or rescheduled.

Patient Responsibility

_____ I understand it is my responsibility to provide a copy of my current insurance card and obtain all necessary authorizations. Should I not provide the required information, I will be personally financially responsible for the total charge of rendered services by C. W. Randolph Jr. M.D., P.A.

_____ I understand that I am responsible for charges not covered or reimbursed by my insurance carrier. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).

After Hours Services

_____I understand that messages left after hours will be returned on the next business day. I know the business hours for Dr. Randolph's Ageless & Wellness Medical Center are:

Monday through Thursday – 8am until 5pm
Friday – 8am until 12noon

_____I also understand that should I be in need of immediate medical attention during the hours the practice is closed, that I should contact or proceed to the closest available urgent care or emergency department for triage and treatment.

Notice of Privacy Policies

_____ I acknowledge receipt of the Notice of Privacy Policies of C.W. Randolph, Jr. M.D, P.A. This Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice. If you have any questions about our Notice of Privacy Policies please contact our Office Administrator.

_____

Signature of Patient or Legal Guardian Date

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● Steven Garces, ARNP ● Jenifer Scott George, ARNP ● Kristin Byers, ARNP ●

AUTHORIZATIONS

(Please Initial and Sign)

Name: _____ DOB: _____

Authorization to Release Medical Information

_____ I authorize the following people to be involved in my care. This consent for disclosure includes both health and financial information as it relates to my care.

Individual's Name (Please Print) Relationship to Patient

_____

_____

_____

_____

_____ I authorize C.W. Randolph, Jr. M.D., P.A to

1. Leave medical information on my answering machine at home? ☐No ☐Yes
2. Leave medical information on my cell phone? ☐No ☐Yes
3. Leave a message at my place of employment? ☐No ☐Yes

_____

Signature of Patient or Legal Guardian Date