

Patient Name: _____

Prescription Refill Policy

Patient Initials

_____ Prescription refills are handled Monday thru Wednesday from 9am to 4pm. Prescriptions will not be refilled after hours or on the weekends.

_____ Refills will not be approved on Fridays or when Dr. Hemler is out of the office.

_____ Requests for prescription refills require an appointment with the clinical assistant. Please be aware of when you are coming to the end of the supply of your medications, emergent appointments can not always be accommodated.

_____ No walk-in appointments for prescription refills will be accommodated.

_____ Prescription refills will only be approved for 3 months or 1 month for controlled substances, after which an appointment with Dr. Hemler is required.

_____ If you need to change the type of medication, an appointment with Dr. Hemler is required. The clinical assistant can not change medications. In emergent situations you may go to Immediacare, after contacting our office.

_____ If you lose or misuse a prescription, we will not authorize a refill without and appointment.

_____ No refills authorizations will be called in or faxed to the pharmacy.

_____ We are not responsible for getting your mail in prescriptions to your mail in pharmacy. This is the patient's responsibility.

Patient Signature

Date

Witness Signature

Sports and Orthopedic Rehabilitation Waivers

Patient Name: _____

Please read and sign all of the following waivers

Assignment of Benefits

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. If my account is referred to collection, I agree to pay reasonable collection expenses including attorney's fees. In the event that I am entitled to health insurance or other benefits relating to my medical condition and available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. I understand that there may be a \$25 charge for cancelling an appointment with less than 24 hours notice or failing to attend an appointment with no notice. Further, I understand that there may be a charge for telephone consultation.

I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I further permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Signature (Must be a parent or guardian for children 17 and under)

Date

HIPPA - Notice of Privacy Notices

I acknowledge that I am in receipt of the Notice of Privacy Practices for Douglas Hemler M.D.

Signature (Must be a parent or guardian for children 17 and under)

Date

FMLA/Disability Form Completion

I am aware that there will be a \$15 charge for all forms completed in the office. This includes but is not limited to FMLA and Disability Paperwork. There is also a two week turn around time for all forms so please plan ahead.

Patient Signature

Date