YOLANDA T GRADY, M.D., INC.
Patient Partnership Plan & Financial Responsibility

We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** *requires a "partnership" between you and your HCP of medical care. As our "partner in health", we ask you to help us in the following ways.*

Schedule Visits for Routine Physical Exams and Other Recommended Health Screenings*--I understand that my Health Care HCP (HCP) will explain to me which regular health screenings are appropriate for my age, gender, personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.).* ***These health screenings are tests that can help detect life threatening diseases and conditions.*** *If I visit my HCP only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.*

Keep Follow-Up Appointments and Reschedule Missed Appointments*—I understand that my HCP will want to know how my condition progresses after I leave the office. Returning to my HCP on time gives them a chance to check my condition and my responses to treatment. During a follow-up appointment, my HCP might order tests, refer me to a specialist, prescribe medication(s), or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my HCP will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.* ***However, if my appointment is not cancelled or rescheduled no later than 4 (four) hours before the scheduled time, I understand that there is a $20.00 missed appointment fee.*** *No exceptions will be made. Three consecutive missed appointments without notifying the office will be grounds for dismissal from the practice.*

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FOR EMERGENCIES AND OTHER URGENT MATTERS*—I understand that I can call the office after hours & the doctor will be reached by the answering service.* ***If the call is not urgent*** *the message will be forwarded to the doctor in the morning. Your call will be returned as soon as possible.*

Call the Office When I Do Not Hear the Results of Labs and Other Tests*—I understand that my HCPs goal is to report my lab and test results to me as soon as possible. However, if I do not hear from the office within the time specified, I will call the office for my test results.*

Medications Will Be Re-filled Only During Office Hours*. I will allow the office 3 (three) business days to authorize a re-fill of my medication (s) and I will call my pharmacist 5 (five) days before I run out of my medication(s). I understand that Diet pills will only be re-filled upon an office visit. Narcotics (pain medications) and nerve pills (anxiety medications) will ONLY be re-filled during office hours. Monthly office visits may be required prior to a refill of these medications.*

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan*—I understand that after examining me, my HCP may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication(s), referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that* ***not*** *following my treatment plan can have serious negative effects on my health. I will let my HCP know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.*

(CONTINUED ON BACK SIDE)

Payments are due at the time of service (co-payments are due prior to seeing my HCP)*—I understand that unless prior arrangements are made ALL payments are due at the time of service. The office accepts Cash, Personal Check, Master Card and Visa. All billable charges for medical services will be billed to my insurance company as a courtesy. I understand that I am (or responsible parties are) personally responsible for payment to the office.*

Hospital charges, lab-work etc. may be billed to me separately by another party and are in no way to be considered a part of the office fee. Yolanda T. Grady, M.D., Inc. is a provider for several PPO and HMO insurance plans, If Dr. Grady is a provider under your plan, we will file a claim for you. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowable, determined by each insurance company. This applies to insurance companies that pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule which bears no relationship to the current standard cost of care in the area. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is my responsibility as a patient to know what my insurance covers.

I understand that insurance companies do not always pay the entire bill. I also understand that any balance after payment is made, (minus adjustments) will be billed to me and I will pay the bill promptly (to avoid interest). I am responsible for all non-covered services, this includes Medicare non-covered services. I also understand that my insurance is a contract between myself, my employer and the insurance company. Dr. Grady's office is not a party to the contract. The office does not accept insurance forms in lieu of payment. If the office does not have a current contract with your insurance company we will provide you with a receipt that will assist you in collecting payment from your insurance company. Frequently insurance companies require additional information from the patient before processing a claim. I agree that if I receive such information in the mail I will complete the form and mail it to the insurance company as soon as possible. I understand that failure to complete the requested information in a timely manner may make me responsible for the entire bill, regardless of the office's contract status with my insurance company.

The office does not file third party insurance claims for workers comp or personal injuries. I will report all work related injuries to my employer and they will send me to the appropriate provider. If personal injury protection (PIP) insurance is available to me I understand that it will become the primary insurance which will make my health insurance secondary. I understand that the office does not wait for claims to be settled in or out of court.

Thank you for your partnership. As a patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask. I hereby authorize the evaluation and treatment by Yolanda T. Grady, M.D., Inc. I also authorize Yolanda T. Grady, M.D., Inc. to furnish any medical information, to any specialist(s) and insurance companies for the purposes of obtaining payment. I further authorize any specialist(s) and all other health care providers to furnish all medical information concerning my present illness or injury to Yolanda T. Grady, M.D., Inc. I agree to allow the faxing of this information when necessary. I also authorize Yolanda T. Grady, M.D., Inc. to review my external Rx history with pharmacies. I understand and agree that the signatures and dates on this form will not expire without written notice, or in the case that a minor becomes an adult and a photocopy of this form is considered as valid as the original.

_____ *Date:*_____

Signature of Patient, Parent, Guardian or Personal Representative.

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Patient Name (Please print)