OFFICE POLICY

Peninsula Nephrology Associates, P. A.
1821 Sweetbay Drive, Suite 1
Salisbury, MD 21804
410-546-4427

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality of care in a caring and pleasant atmosphere. To be fair to all our patients, we ask that you read and remember the following policies:

1. Always bring proof of insurance and a photo ID.
2. Let us know if there are any changes of address, phone numbers, etc.
3. Please be on time for your appointment. We have reserved a particular time for you, and we do our best to stay on schedule. Please keep in mind that situations do arise, and we may at times be a bit behind schedule based on patients' needs.
4. We bill to most insurance companies and ask if a referral is needed from your insurance for you to be seen that you take responsibility in making sure we have this prior to your appointment or you can bring one in at the time of your appointment. If we do not have the referral at the time of the appointment, the appointment will be rescheduled.
5. Co-Pays are due at the time of your visit. We accept cash, checks, Visa, Mastercard, and money orders.
6. There will be a $35.00 service fee for all returned checks.
7. Any balance on your account after an insurance payment is made is your responsibility. Payment is expected within 30 days of receipt of the statement sent to you.
8. Please note at times we must correspond with your primary care provider or other specialist in regard to your care and we may do this through email, electronic files and fax.
9. We ask that if you are unable to make your appointment that you call wihtin24 hours to reschedule so that we may get another patient scheduled. No shows present a problem in any office and we just ask as a courtesy that you call us. If you do not call us 24 hours in advance to reschedule or cancel your appointment:
    - ★ Your appointment will be considered a "NO SHOW".
    - ★ You will be charged $50 if it is a consultation and $25 if it is a follow up.
    - ★ We do understand that emergencies arise and do our best to work with our patients the best we can.

AUTHORIZATION

I have read and accept the above office policy, understand it and agree to the terms set forth regarding payment.

Signature: _____ Date: _____