

Lillian M. DeCosimo, M.D.

10694 Crestwood Drive Suite A

Manassas, VA 20109

Tel: 703-222-8600 Fax: 703-222-8972

drdecosimo@aboutcaregyn.com

Patient Responsibilities & Office Policies

- All patients, please arrive at least 15 minutes before your scheduled appointment to complete our patient registration process. For speedier processing, you can review our forms at: www.aboutcaregyn.com, as you will be asked to sign acknowledgement of these forms and policies when you arrive. You will also need to present your insurance, a valid VISA or MasterCard credit card and photo identification.
- We ask that you please familiarize yourself with your insurance policy. Every policy has its own rules and regulations. It is in your best interest to know what your covered benefits are, if referrals are required OR if Dr. DeCosimo is a participating provider. If you come in without getting proper referrals, you understand that **you** will become responsible for any service rendered.
- Please make sure you provide accurate personal and insurance information. If your information is not correct, **you** will be responsible for your bill in full. Unfortunately, we can't see you without all required information completed.
- Dr. DeCosimo orders tests that are medically necessary. It is your responsibility to know what tests your insurance policy covers and which one(s) it does **not**. Certain blood tests, in office testing, radiology, sonography and/or mammography may not be included in your coverage.
- All appointments must be scheduled in advance. There is a **\$100.00 fee** for a missed appointment or if you fail to cancel an existing appointment without a 24 hour notice. If this fee is incurred, and you fail to pay it, this will lead to your dismissal from the practice. We do understand that certain emergencies can arise, however, we ask that you schedule an appointment for a time in which you are confident you can make, so that you may avoid our **\$100.00** broken appointment fee.
- Co-payments must be made at the time services are rendered. Co-payments are required for lab work, for nursing medication administration visits and dropping off of specimens.
- There is a fee for copying medical records. There is a **\$10.00** processing fee plus **\$0.50** per page. Processing your request may take up to **15** business days, so please make sure your "Medical Records Authorization Release" form is submitted in the appropriate time frame. Expedited requests will be charged an additional **\$30.00** processing fee.
- Please be advised that we will notify you by mail or email of test results. Test results that require additional testing or that are abnormal **will require** a consultation appointment with Dr. DeCosimo to discuss the results. To protect your confidentiality, results **WILL NOT** be discussed over the telephone or by email.

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- If you ever have a medical emergency, please call 911. Never leave a voice message for an urgent concern. Please follow our voice mail prompts to page the doctor immediately.
- When calling our office and leaving a message, please leave a detailed message clearly stating the nature of your concern or request, with your contact information and date of birth. Your message will be relayed to the doctor on our next business day or you may **email** Dr. DeCosimo directly at: drdecosimo@aboutcaregyn.com. You will receive a response within 48 hours (for problems deemed non emergencies) with the doctor's recommendations. If you need to speak to the doctor, personally, an appointment will be necessary and usually can be arranged within 24-48 hours.
- Requests for **prescription refills** of any kind, we will require **72** hours to process. A **\$15.00 fee** will be billed to you **per** prescription(s) that you may need refilled before your scheduled appointment, rewritten or called in to a pharmacy for **any** reason (example: If you require the prescription to be rewritten for mail-in pharmacy, lost prescriptions or need it reprocessed in some other manner, after one was issued **by the doctor** at a scheduled appointment).
- There is a **\$25.00 fee** for any letter or note needed to be excused from work or any other activity due to medical necessity, disability forms, preauthorization letters requested by insurance for certain prescription or service(s) coverage. Two or more pages for these types of forms will be **\$20.00** per page.

I have read, understand, and accept the above office policies.

Patient Name: _____

(Please print clearly)

Patient Signature: _____

Date: _____