

Nina Lee-Tall, M.D., Inc.
23456 Hawthorne Blvd. #290
Torrance, CA
(310) 375-2102 Fax (310) 791-6319

To improve efficiency in the office, and to better serve patients, the following policies will be instituted:

(Please read and initial the following items)

_____ It is your responsibility to inform my staff of any insurance changes. My staff will make every effort to verify eligibility and coverage at the time of your visit. If we are unable to do so, you will be required to pay for the visit at the time of service. You will be responsible for billing your insurance for that date of service, should you wish to be reimbursed.

_____ It is imperative that my staff has your current address and phone number. Please notify us of any changes.

_____ Co-payments are due at the time of service. There is a \$5 service charge for the non-payment at the time of service.

_____ There is a \$20 charge for all returned checks. Repeat occurrences will result in a "cash only" policy.

_____ Statements are sent monthly. If your account is over 90 days delinquent you will be seen on a "cash only" basis. You will be required to pay your balance prior to future medical services.

_____ Cancellation policy: As a courtesy, my staff will call to remind you of a visit one day in advance. All "no-shows" are charged \$50. This \$50 charge is not billable to your insurance company. Patients with multiple late cancellations (day of appointment) will be charged \$50.

_____ Late Policy: We respect your time and make every effort to see you at your scheduled appointment time. In turn, we expect you to arrive on time. When you arrive 20 minutes past your appointment you have missed your appointment and you will need to reschedule.

_____ In accordance with the laws of the State of California, I do NOT prescribe medication for patients over the phone for a new illness. A visit must be scheduled.

_____ Three "no show" appointments will result in our office asking you to transfer medical care to another physician.

Patient(s) Name _____

I have read, understand, and agree to the above stated policies.

Patient/Parent Signature _____

Date _____