LOTUS
Spine & Pain

Please read carefully before signing. A copy will be provided to you.

We appreciate the opportunity to serve you. The following information and expectations are set forth in an effort to provide all our patients with the highest quality of care.

- **MEDICATION REFILL REQUESTS:** Refills should be requested **3 BUSINESS DAYS** prior to refill date. The practice is closed on weekends and holidays, therefore refill requests left via voicemail will not be received until the following business day. Failure to request refills prior to weekends/ holidays may result in a prescription not being filled before the due date. Prescriptions may not be written on the same day they are requested.

- **FMLA AND OTHER FORMS:** Should you require our office to complete FMLA or any other forms, there is a **fee of $30 that is due upon completion of forms.** In order for forms to be completed correctly, we may require you to set an appointment with Dr. Jones to go over the forms.

- **APPOINTMENT TIME:** We ask that you arrive **on time** to your appointment. Arrivals more than 15 minutes late **will require a reschedule.**

- **CANCELLATION/ NO SHOW:** If you need to cancel your appointment, we ask that you give us 24 hour notice. If you fail to notify us and miss your appointment, **there will be a $25 fee**. Two same day no shows are grounds for termination from the clinic. **There will also be a $25 dollar for same day rescheduling.**

- **PAYMENTS:** All applicable fees, coinsurance, deductible, copays, or outstanding balances must be paid at the time of your appointment unless prior arrangements have been made. We accept cash, credit/ debit, and checks. **There is a $25 fee for returned checks.**

- **OFFICE VISITS:** At the time of scheduling, please notify the staff for all the reasons you are requesting an appointment. Multiple complaints will be addressed but may require multiple visits.

By signing below, you are acknowledging that you have read, understand, and are in agreement with the above expectations and information.

_____	_____	_____
Patient Signature	**Printed Name**	**Date**