Bibb Family Practice Associates, PC
Sam G. Amporful, M.D.
721 RIVERSIDE DRIVE LANE
MACON, GA 31201
(478) 259-3439

# TERMS AND CONDITIONS

Please review our terms and conditions of treatment within this facility and initial by each statement.

_____ **COMPLETION OF A MEDICAL CLEARANCE**: Requests by new patients to have a medical clearance completed should be made in advance. Due to the complexity of a medical clearance we will not be able to clear you at your initial visit. Depending on your medical history and/or the requirements of the clearance we may require you to see a specialist or have further testing. We will not be able to complete the clearance until we have obtained all the needed information. Your understanding and patience is appreciated in this matter.

_____ **ARRIVAL TIME FOR ALL PATIENTS:** All patients who arrive l5 minutes or more after their scheduled appointment time will be rescheduled or may wait to see if they can be worked in. Wait times vary and are not a guarantee you will be seen.

_____ **ASSIGNMENT OF BENEFITS:** I authorize my insurance company to pay directly Bibb Family Practice the cost allowable and otherwise payable to me under my insurance policy, applicable to the professional services rendered. I agree to pay all charges not covered by insurance payments or if I receive payment from insurance filed by your company, I will forward the payment to your office within one week of receipt of funds.

_____ **CONSENT FOR TREATMENT:** I authorize Bibb Family Practice and such assistants as they may designate, to carry out diagnostic procedures if needed to better diagnose my condition and to administer such treatments and medications, as indicated. I understand that my condition may call for a consultation with another physician. If this situation occurs I authorize Bibb Family Practice to release medical information that may be needed to better provide for my medical.

_____**PAYMENT AGREEMENT:** The foregoing information is true to the best of my knowledge and I request Bibb Family Practice to provide me and/or my family with medical care. I acknowledge my responsibility to pay for services according to the policies established by Bibb Family Practice.

_____**COMPLETION OF FORMS (FMLA | INS Form | Worker's Comp | Disability Claims):** Request by patients to have forms completed should be made in advance. If you need a form completed, please furnish us with a copy of the form prior to your visit. Some lengthy forms will require a separate office visit to complete the required examination. If such a visit is required, regular office visit charges/copayments will apply. Please be advised that we cannot always complete these forms - some require the services of a specialist.

_____**CONSENT TO AN RX HISTORY**: I consent to provide Bibb Family Practice access to and use my prescription medication history from other healthcare providers for treatment purposes. I understand this consent shall remain in effect as long as I am a patient of Bibb Family Practice unless revoked in writing.

_____**INITIAL TREATMENT OF CHRONIC PAIN MANAGEMENT AND OR TREATMENT OF ADULT ADD/ADHD:** WE DO NOT PROVIDE TREATMENT WITH NARCOTICS FOR PAIN MANAGEMENT. WE DO NOT PROVIDE MEDICATION MANAGEMENT OF ADULT ADD/ADHD.

Patient / Guarantor Signature:_____ Date: _____