Compassionate Care for Women

Lawson C Richter, MD

We would like to welcome you to our practice. Your participation in your medical care is very important for the treatment of your medical condition. We have outlined some tips to help maximize your success.

CCFW Office Policies

1. Payment is due at the time of services rendered this includes balance on account, insurance co-pay, co-insurance and deductibles.
2. Follow-up appointments need to be made before leaving the office.
3. Refills request MUST come by fax from your pharmacy. There are NO EXCEPTIONS.
4. We will bill your insurance as a courtesy. It is your financial responsibility for any unpaid balance.
5. It is your responsibility to inform the office immediately of any changes in address, phone number/s, work information or emergency contact.
6. It is your responsibility to inform the office immediately of any changes in your insurance.
7. Failure to inform us of any changes in your coverage you are therefore voluntarily waving your right to use your insurance. All charges incurred from that point will be your responsibility.
8. It is your responsibility to understand and be informed of your insurance benefits. Please check with your insurance company or human resources department if you have any questions or concerns.
9. There is a **$25.00 fee for returned check**; thereafter no check pmt will be accepted.
10. There is a **$80.00** No Show fee, you must cancel at least 48hrs in advance otherwise there is a **$80.00** fee which is your financial responsibility.
11. If you need any **forms** filled out there is a **$50.00** minimum fee and it is approximately 24-48 hours to complete.
12. If you need a **letter** from Doctor or our PA there is a minimum fee of **$75.00**, depending on the complexity of the letter the fee maybe more. There is approximately 48-72 hours to complete your request.
13. In the event that your account should be place in collections you will be responsible for accrued interest, collection fees, court fees and any legal fees incurred.

I have read and understand the above policies in their entirety. I agree to abide by these policies.

Print Patient's Name	Guardian if Minor	Date

Patient Signature	Guardian Signature