FOOTHILL PULMONARY AND CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

959 E. Walnut St., Suite 120
Pasadena, California 91106
(626) 795-5118

301 W. Huntington Dr., Suite 607
Arcadia, California 91007
(626) 445-4558

1818 Verdugo Blvd., Suite 207
Glendale, California 91208
(818) 790-1730

101 E. Beverly Blvd., Suite 307
Montebello, California 90640
(323) 888-2548

CHARLES A. ANDERSON, M.D.
JOHN P. CARMODY, M.D.
LUIS L. DIMEN, M.D.
KATHLEEN JONES, M.D.
ELTON KATAGIHARA, M.D.

MARK KROE, M.D.
CARLOS G. MAKABALI, M.D.
RAJIV PHILIP, M.D.
CHITRA RAMAKRISHNAN, M.D.
DAVID R. RATTO, M.D.
PRATAP SARAF, M.D.

LINDA Y. C. SHEN, M.D.
LEO SHUM, M.D.
ROBERT SIEW, M.D.
STANLEY TU, M.D.
JOHN J. VAN DYKE, M.D.

STANLEY TU, M.D.

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Dear Patient,

In order to serve you, our valued patient, in a more efficient manner, please be advised of the following office policies:

1. Medication Refills:

Please have your pharmacy contact our office 3 to 5 days prior to when your medications are expired or completed. Practice good healthy habits and call us with your medication requirements prior to completion of your prescription. This policy allows you to take your medication without any interruptions or compromise in your health and well-being.
Routine medication refills (*including all CPAP and BiPAP equipment*) require at least one yearly follow up exam with your physician.

PRESCRIPTION REFILLS ARE NOT PROCESSED ON SATURDAY OR SUNDAY OR AFTER HOURS. Please allow 48 hours for all refills to be processed. Patients *must* be seen within one year for any refills. We are not responsible for your prescription plan coverage. Please read your medical plans pharmacy policies.

2. Laboratory/Diagnostic testing:

All test results are reviewed by the ordering physician within 1 working day of receiving the results. Patients will only be notified of abnormal test results requiring treatment. Patients are always encouraged to contact our office during normal business hours (Monday through Friday 9 a.m. to 5 p.m.) to obtain verbal results from our nurse.

3. Cancelled/Missed Appointments:

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than a 24 hour notice, Foothill Pulmonary reserves the right to bill the patient according to the scheduled fee or according to the rules of the patient's health plan. You will be billed unless another appointment is made.

4. Authorization/Eligibility:

Because of the contractual relationship between Foothill Pulmonary and all managed care insurance plans, I am aware that every visit requires pre-authorization prior to any procedures or lab tests, which may delay health care. Co-payments are expected to be paid at the time of service and are required for each visit.
AUTHORAZATION FORMS MUST BE PRESENTED AT THE TIME OF SERVICE OR YOU MAY BE REFUSED SERVICE OR BE RESPONSIBLE FOR THE BILL AT THE TIME OF SERVICE.
I understand I must be seen prior to the expiration date of the authorization, and must be eligible with the insurance at the time of service. I will notify the office of any change in my insurance, primary care physician, or demographic information. Failure to do so may delay the billing process and/or medical care.

5. Disability forms and other non-insurance forms:

Due to the complexity of completing certain disability forms and other non-insurance forms, effective August 21, 2008 office has instituted a charge of $35.00 per form to complete these forms. This includes but is not limited to SDI, FMLA, DMV, Electric or Gas Company, jury duty, and airline forms. If you have any questions about this fee, please speak with one of the office staff.

Please be advised, if 3 years have passed since your last visit you will be considered a new patient.

We provide this information because we would like you to be able to plan for your entire health care needs and not inappropriately rely on a limited purpose visit as if it were a comprehensive examination of your overall health.

Your on going partnership and working relationship with our office and staff allows us to better meet your medical needs. We appreciate, very much, your cooperation and adherence to our policies. We understand the need for personalized medical care and we strive to meet your needs.

Do you have any personal, religious, or cultural preferences which may affect of influence the way you want to be treated?

Yes__________ No__________

If you answered yes, please explain

____

____

I agree to allow the physicians of Foothill Pulmonary to render medical care to:

____
Patient's Name

I have read and understand the above information and agree to all of the terms stated above.
My signature below represents my acceptance of these policies.

__________________________________ ____________________
Patient's signature Date