

RONI W. FORD, M.D., L.L.C. AND ASSOCIATES  
19211 MONTGOMERY VILLAGE AVE  
SUITE B-12  
MONTGOMERY VILLAGE, MD 20886

**PATIENT POLICIES**

As a patient of Roni W. Ford, M.D., L.L.C. and I understand it is my responsibility to provide accurate and complete information regarding my medical needs, medical history, medications, demographics, and health insurance.

- It is my responsibility to provide proof of identification (driver's license) and current insurance information prior to or upon arrival for my appointment (parent's information in cases of a minor)
- It is my responsibility to provide a valid referral (if required by your insurance company) prior to or at the time service. If a valid referral is not available at the time of your appointment, you will be asked to pay the full amount of the visit or reschedule your appointment once a valid referral can be obtained.
- It is my responsibility to sign a HIPAA Privacy Act acknowledgement statement
- It is my responsibility to report changes in my medical condition, medications, demographics or insurance to the physician and/or staff.
- It is my responsibility to request additional information about my medical condition or treatment when I do not fully understand the information or instructions given to me.
- I understand that there is a medical records copying fee and a per page copies fee, as allowed by Maryland Law. This fee must be paid before records will be sent.
- I understand a fee of \$30.00 will be imposed for any checks returned due to insufficient funds.
- I understand that my appointment time is reserved for me only and it is my responsibility to give 24 hours notice when canceling an appointment. There will be a \$50.00 fee if I fail to cancel a 30-minute appointment without 24 hours notice and \$25.00 fee if I fail to cancel a regular 15-min appointment without 24 hours notice.
- I understand that it is my responsibility to pay any outstanding balances, insurance deductibles and co-pays at the time of service.
- I understand that payment on all statements is due upon receipt.
- I understand that any uncollected balances on my account will be referred to an outside agency for collection and in these cases, a 40% service charge will be added to my outstanding balance. I also acknowledge that failure to pay will be reported on my credit reports.
- I understand that it is possible that my insurance company may deem a dermatologic procedure as cosmetic (such as removal skin tags or other benign growths) and I agree to be financially responsible for these charges should this occur.

I certify that the answers to the questions above are true, correct and complete to the best of my knowledge. I also acknowledge and accept the patient policies stated above.

**SIGNED:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_