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Family
FAMILYPRACTICEASSOCIATES, P.A.

BOARD CERTIFIED BY THE AMERICAN BOARD OF FAMILY PRACTICE

Welcome to Family Practice Associates. We are pleased to have you join our family. Please carefully review the following information regarding our services:

Office Hours:
Monday-Thursday 8:00 a.m. – 5:30 p.m.
Friday 8:00 a.m. - 5:00 p.m.
Saturday 8:00 a.m. - 12:00 p.m.

Please be advised that our office hours may vary during specific periods throughout the year. The afterhours recording reflects the accurate operating hours at all times. Our office hours may be affected by adverse weather conditions. Please keep our number handy…it is 830-896-4711. Saturday hours are reserved for sick patients who become sick after hours Friday and are seen on a walk-in basis only. Appointments are not required on Saturdays.

Sick Hours:

Sick appointments are scheduled throughout the day. Same day sick appointments refer to those appointments scheduled on the day of your illness.

Appointment Scheduling:

To schedule an appointment, please call (830) 896-4711. In an effort to provide expedient services to all patients, we ask that if you need to cancel or reschedule an appointment please call our office at least 24 hours ahead of your appointment time. Failure to call the office could result in a $25 no show fee (effective 09/19/2008). Patients arriving 15 or more minutes beyond their scheduled appointment time will be asked to reschedule.

We want to reduce the wait time for all patients…please arrive 10-15 minutes early to insure you are on time for your visit.

Additional Services:

Full range of healthcare services, including adults, children, and women health.

Provide Hospital care.

Lunch hour appointments.

A nurse is a phone call away! During office hours, parents may speak with our triage nurse who provides information on a wide range of medical topics.

For added convenience, use our Prescription Line 896-4711, option 3 & 1.

Insurance Billing questions 830-896-2902.

In preparation for your visit:

For the initial visit, please plan to arrive 30 minutes prior to your appointment time to complete the registration packet. For all other visits, please arrive 15 minutes prior to your appointment time. Also, please, remember to bring your current insurance card with you. To avoid unnecessary out-of-pocket expenses, be sure that our doctors are listed as your primary care physician (PCP).

OUR MISSION

Family Practice Associates, P.A. is dedicated to serve the Hill Country community. Providing quality medical care with compassion to our patients and their families, promoting physical, mental and spiritual well-being.

Family Practice Associates Financial Policy

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Family Practice Associates accepts cash, personal check, Visa, MasterCard and Discover. There is a service charge for returned checks of $30.00.

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Patients with an outstanding balance of 60 days overdue must make arrangements of payment prior to scheduling appointments. We realize that people have financial difficulty. Therefore, we may advise that due to your financial situation to set Financial Arrangements, not to exceed 90 days.

Patient with and with out insurance are eligible to receive a discount when applicable. If the patient is under insured or has a high deductable or has no insurance. There will be an automatic 25% discount for patients who are in good standing with the practice, i.e. have a zero balance and pay their current bill in full at the time of service. *(Effective; 04/2008)*

The Cashier will collect 20% for all office procedures. The cashier will make the patient aware that their insurance may not cover some care that the patient or FPA health care provider has good reason to think the patient needs. *(Effective; 02/2008)*

Insurance: We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received a payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges. We do bill secondary insurance companies as a courtesy to you.

Your time of service receipt includes all information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact the Billing department between 8:00 a.m. and 4:30 p.m. Monday through Friday at (830) 896-2902.

Refunds: Overpayments will be refunded upon written request to the responsible party within 30 days of request.

Medicaid
If you are enrolled in a managed care insurance plan, (i.e., Superior, TexasStar, and PCCM), you must receive an Administrative referral or Authorization *before* seen **NO** retroactive referrals will be given. If Family Practice Associates or any of our Providers (Dr. John Davis, Dr. David Sprouse, Dr Karsten Tucker, Debbie Jalbert, PA-C, Anne E. Shackelford FNP-C, or Dr. Javier M. Campos) is not the primary care provider you will be responsible for your visit.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand Family Practice Associates Financial Policy. I agree to assign insurance benefits to Family Practice Associates whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or authorized representative: _____

Patient Name: _____Patient D.O.B. _____Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: (source)

_____

Physician/Facility

_____

Mailing Address

_____

To Release Medical information of:

_____

Patient Name

_____

Social Security Number

_____

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City, State, Zip Date of Birth

Fax: _____

Phone: _____

TO BE RELEASED TO: FAMILY PRACTICE ASSOCIATES, P.A., 220 WESLEY DRIVE, KERRVILLE TX 78028
ON DISK must be PDF or Word formatted

DO NOT FAX MEDICAL RECORDS

Information to be released:
I hereby authorize the above named source to release or disclose: all medical records or other information regarding my treatment, hospitalization, and/or outpatient care, including, but not limited to, psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, AIDS (Acquired Immune Deficiency Syndrome), symptomatic HIV infection, and HIV antibody testing.

Reason for release:

- Moving – new address _____
  City State Zip Phone/Cell
- Changing Treating Doctors
- Other _____

Please release information ☐ via: ☐ Mail Pick up, phone/cell No. _____

"Medical Records" means information recorded in any form or medium that indentifies the patient and relates to the patient's history, diagnosis, treatment or prognosis. Note: Texas law authorizes the release of health care information without patient authorization in a number of situations, including disclosures to a third-party payer such as insurance companies if the disclosure is to reimburse the health care provider, or the patient, for medical services and supplies. This authorization is valid for 90 days from the date of signature, unless I specify otherwise or revoke it.

_____ _____
Signature of Patient or Auth. Agent Date

_____
Relation to Patient

PRESCRIPTION REFILL POLICY

To our patient

Please follow the procedures outlined below when calling the office to request a refill.

Prescriptions are written and/or called in to the pharmacy at the end of the business day;
Refill requests left on the voice mail after hours, on holidays or weekends, will be processed on the next regular business
day. ***Please do not wait until you run completely out of a medication to request a refill.***

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You may come by to pick up the prescription, but please call the office first to make sure that the prescription has been written and is waiting for you. We cannot stop and fill the prescription immediately, just when a patient or patient's parent walks in.

Ritalin, Adderall, and Dexedrine cannot be called in; ***this type of prescription must be written and filled within twenty-one days of the date of the prescription*** *(rvsd; 2009),* ***or it will expire and the pharmacy will not honor it.*** If you allow the prescription to expire, there will be a $10.00 charge to reissue the prescription, and you will need to pick up the prescription and pay the fee at that time.

Please follow these steps when you need a refill of Ritalin, Adderall or Dexedrine;

1. If you live at a distance or it is inconvenient for you to come by the office to pick up the prescription, send us a supply of stamped, pre-addressed envelopes that we can keep in your chart, so that the prescription may be mailed to you.
2. For written prescription, please leave the following information on the voice mail: Patient's name, age and address, including zip code, name of medication and dosage, whether you pick up the prescription or want it mailed.

It is very important that you stay in close contact with the school nurse, in order that you are able to give us plenty of warning as to when the school may be getting low on medication. Our intent is to increase efficiency and provide better service to you so that prescriptions are ready for you or mailed to you. Please help us in this regard.

MEDICAL ARTS PLAZA, 220 WESLEY DRIVE, KERRVILLE, TEXAS 78028
830.896.4711 ✦ FAX 830.257.0878 ✦ FPA-DOCS.COM

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_____
Patient name

_____
Date of Birth

Rx (Prescription) History Consent

Patient or Authorized Person's consent

I authorize the Provider of Family Practice Associates, P.A. to view my prescription history form other external sources.

With this consent, Family Practice Associates, P.A. Provider(s) may view my prescription history when seen by other providers that have prescribed medications elsewhere to assist the Family Practice provider(s) in carrying out treatment.

Y Yes I give my consent to view my prescription history

_____
Patient or Authorized Person

_____
Date

N No I do not give my consent to view my prescription history

_____
Patient or Authorized Person

_____
Date

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