Mesa Family Physicians
OFFICE POLICIES

To protect your privacy as outlined by HIPAA (Health Information Portability Accountability Act), please indicate below who we may release medical information to. We will need to know the name and relationship to the patient. (Please print)

1. _____ Relationship to you:_____
2. _____ Relationship to you:_____
3. _____ Relationship to you:_____

I further acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Please carefully read and initial by each statement below to indicate understanding of ***Mesa Family Physicians*** policies.

1. _____ **DOCUMENTATION TO BE COMPLETED:** To ensure accuracy in the completion of any forms by the providers, we require an office visit. There will be no exceptions.

2. _____ **MEDICAL RECORDS REQUEST:** Medical records will be sent to another provider at no charge. There will be a $35 to $50 charge (depending on the size of your chart), for patients requesting a copy of their personal medical records.

3. _____ **MINOR AGE PATIENTS:** ***Mesa Family Physicians*** requires that a parent or legal guardian accompany all minor patients. The parent or legal guardian that accompanies the minor for medical services will be responsible for payment.

4. _____ **RELEASE OF INFORMATION:** I authorize ***Mesa Family Physicians*** to release any information acquired in the course of my treatment as required for processing insurance claims. I also authorize the release of my medical information to any requesting source presenting a signed authorization by me.

5. _____ **AUTHORIZATION TO TREAT:** I hereby authorize the staff of ***Mesa Family Physicians*** to provide me with medical treatment. I agree to inform them if I have any concern about my medical treatment at the time the services are being rendered.

6. _____ **CALLBACKS:** When leaving a message for a provider, please disclose the reason for the call. This in the long run will expedite your call through our office. Also keep in mind that all patient callbacks will be done after all patients in the office have been seen. Non-urgent messages will be returned within 24 hours.

7. _____ **PRESCRIPTION REFILLS:** Whether you need medication called into your local pharmacy or mail-in pharmacy, **please contact the pharmacy for refills.**
   Please allow 48-72 hours for all prescription refills. **If you are completely out of your medication or requesting an antibiotic, you MUST schedule an office visit for any refills. Also, please note – We do not refill prescriptions on Friday afternoons. PLEASE PLAN AHEAD.**

8. _____ **CONSENT TO RECEIVE MESSAGES:** I hereby authorize the staff of Mesa Family Physicians to notify me of test results or other non-urgent messages to the phone numbers provided in my chart. I further understand that if I revoke this authorization to receive these messages on either my cell phone # provided or my home # provided, I will need to call the office and schedule an appointment to go over these results.

9. _____**REFERRALS/PRIOR AUTHS:** It is your responsibility to make sure the specialist is in your network. Notify our office 1 week prior to your appointment with the specialists information to complete the referral. For prior authorizations for medications, your insurance company has 72 hours for urgent requests to process and 30 days for routine requests.

Printed name of patient	Signature of patient / Resp. Party	Today's Date