

FLORY ISABEL AGUILAR, M.D.

HOAG HEALTH CENTER IRVINE

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Office Policies

Our fortunate extensive growth in the past few years is largely due to referrals from our clientele such as you. At our office we strive to offer personalized patient care. In order to continue to achieve the highest quality of care, we place tremendous value on the doctor-patient relationship. We ask for your understanding, and, as our valued patient, we would appreciate your assistance in implementing the following office policies:

Copayments and outstanding balances are due at the time of service

Please allow at least 24 hours for all medication refill requests (Monday-Friday); please contact your pharmacy for the refill request and the pharmacy will contact the office. This will expedite your request.

No medication will be refilled on weekends or after-hours. All after-hour calls are subject to a fee directly billed to the patient.

A 24 hour cancellation notice is required for all appointments.

A \$50.00 fee will be assessed for all missed appointments (“no show”) without a 24 hour notice. Again, due to our growing practice, it is important to accommodate others.

It is the *patient's* financial responsibility to be familiar with their individual insurance plans including contracted imaging facilities, contracted laboratories (We currently use Westcliff or Quest), and all other ancillary facilities. Please contact the respective facility for any billing questions in regard to the testing.

Due to an overwhelming demand, Dr. Aguilar will no longer offer free telephone consults. Please leave a detailed message with our office staff and allow 24 hours for all call-backs and scheduling. Please provide the nature of your call, as it will determine the priority of your call-back. It is always best to discuss your health in person.

All “Personal” phone calls require an office visit.

A \$25.00 fee will be assessed for all forms and letters to be completed by Dr. Aguilar.

A \$25.00 fee will be assessed for all NSF checks and copying of records.

A \$35.00 fee will be accrued for every 30 days of an overdue balance.

A \$50.00 fee will be assessed for failure to notify the office of any changes in your insurance coverage at the time of service.

All outstanding balances of >90 days will be transferred to our Collection Services.

Patient Signature: _____ Date: _____

Please let us know your preferred method of communicating all confidential medical information with you (check all applicable methods):

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Email: _____