

Pacific Frontier Medical, Inc.
Notice of Practice Policies

Please initial the following Practice Policies as a sign of you understanding of each policy.

1. Patients being treated with antibiotics must be seen every 4 to 12 weeks during treatment as recommended by the practitioner. Patients who live 6 or more hours away from the practice may have a phone consultation between follow up visits to obtain their prescription renewal.
Initial_____
2. Prescription renewals (other than antibiotics) can only be filled if the patient has had a follow up appointment or phone consultation within the past 3 to 6 months, as recommended by the practitioner. We will require a patient to have follow up appointments to receive a prescription renewal if the patient has not been seen within the past 3-6 months.
Initial_____
3. Payment is due at the time of service. If you cannot make full payment; other arrangements must be made with our Practice Manager prior to the appointment or service. We do not bill insurance and we are not a Medicare provider.
Initial_____
4. Supplements purchased from out office cannot be returned after they leave the office since we cannot monitor the environmental exposure they may encounter.
Initial_____
5. The backline phone is for emergencies only.
 - Do not call the backline during office hours. Please call the nurses line for any questions or concerns since the practitioners are seeing other patients.
 - The backline is available after hours and on weekends for true emergencies. Abusing the emergency line with non-emergency calls will result in the privilege being suspended.Initial_____
6. Current patients who fail to call or cancel and appointment within 48 business hours prior to the appointment will be assess a late fee. New patients must cancel or change their appointment 7 business days prior to their appointment in order to receive a refund of their deposit.
Initial_____
7. For safety of our staff and other patients, we will not tolerate threatening and/or aggressive behavior or sexual advances. Anyone exhibiting this type of behavior(s) will be immediately dismissed from our practice.
Initial_____

Print Patient Name:_____ Date:_____

If Minor, Print Parent Name: _____

Signature:_____