APGCare

Office Location:
15245 Shady Grove Rd #130
Rockville, MD 20850
(301) 527-1650

Business and mailing address:
P.O. Box 10067
Gaithersburg, MD 20898

OFFICE POLICY FORM

In order to significantly reduce the costs of billing and bookkeeping, we ask that you pay for treatment at the time the services are rendered (including co-pays, deductibles and payment in full for no insurance). We understand that an occasion may arise when it may be difficult for you to pay in full, please let us know before services are rendered and we will try to arrange an acceptable payment plan for you. You will be requested to sign a payment plan and will be expected to meet the payments.

Any returned check will be subjected to a $50.00 service charge. I agree that I am responsible for all charges that incur regardless of the Insurance coverage. In the event my account is referred to a Collection Agency I agree to pay the additional 35% fee that will be added to my account. Payment for the services rendered or to be rendered by the Guarantor whose signature appears below, together with all late charges, attorney's fees, costs and expenses of the collection incurred in enforcing any such liabilities.

As a courtesy to our patients, our office will submit insurance claims. However, follow-up of claims processing is the patient's responsibility. Should your insurance have any questions, we will be happy to provide them with any further information. WE STRONGLY SUGGEST THAT YOU REVIEW YOUR INSURANCE POLICY TO DETERMINE COVERAGE AND PROTOCOLS.

THIS OFFICE DOES NOT FAX OR MAIL!!! (This includes referrals, letters etc.)

Any appointments that are broken without 24 hour notice to the office will be subject to a charge.
Paging the physician for non-urgent matters will also be subject to a charge.

Please remember that if you have any questions about this or any other office procedures or fee schedules, we will be happy to discuss it with you. As our patient, we value you and will continue to provide you with our best professional care.

I have read and understand the above statement.

Patient Signature _____ **Date_____**
(Parent or Guardian)

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I hereby give authorization for you to reveal my test results and/or medical reports to the below listed names ONLY.
Spouse Yes No _____
Children Yes No _____

Patient Signature _____ **Date_____**
(Parent or Guardian)

No, I do not want to give authorization for my results to be given out.

Patient Signature _____ **Date_____**
(Parent or Guardian)

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