

APPOINTMENT AND PRESCRIPTION POLICY

MSU NEUROLOGY CLINIC
804 Service Road, Room A-217
East Lansing, Mi 48824

Welcome to MSU Neurology Clinic!

In order to improve access to our clinic, minimize waiting time for appointments, and be as efficient as possible with prescription refills our office has adopted the following policies:

MISSED APPOINTMENTS

When a patient fails to keep a scheduled appointments three (3) times in twelve (12) consecutive months, it will be necessary for that patient to make arrangements to seek medical care elsewhere.

There may be a fee charged for any missed appointments. **The current fee is \$25.00 and is NOT covered by any insurance plan.** This fee must be paid prior to the appointment being rescheduled.

Further, to avoid being charged for a missed appointment, it will be necessary to have called this office at least one (1) business day in advance of the appointment.

If/when a patient has two (2) missed appointments, a reminder letter will be sent notifying the patient of this status.

Upon failing to keep a third scheduled appointment, a certified letter will be sent indicating that three (3) scheduled appointments have been missed. Within thirty (30) days of the date of the certified letter, the patient and any family member will no longer be able to receive medical care through this office.

NOTE: Patient and/or legal guardians will be held responsible for the appointments of minor children.

PRESCRIPTION REFILLS:

Medical refills require authorization by your physician, who may not be in clinic all days of the week. Therefore, we require **AT LEAST THREE (3) BUSINESS DAYS NOTICE** for processing prescription refills.

If you take more than one prescription, please check for all medications that need refilling rather than making several calls over a short period of time with numerous requests.

When calling in a request for a refill, please use the bottle to read and spell the name, dose, and frequency of the medication(s). Also, state the name and phone number of the pharmacy you want called.

I have read the above Policy and understand how it relates to my family and me.

Please PRINT Patient/Parent Name

Witness Signature

Date

Patient/Parent SIGNATURE

Date