OFFICE AND FINANCIAL POLICIES FOR THE FALCONE CENTER

Thank you for choosing the Falcone Center. We are committed to providing you with quality, personal care and treatment and appreciate your commitment to adhere to this Office/Financial Policy Agreement. Agreement with this policy is required for all medical care and treatments.

Our office policies for Functional, Cosmetic and Integrative Medicine Patients

1. All payments are pre-paid at the time of service unless other arrangements have been made. We accept cash, credit cards and in-state personal checks (PA or NJ) with driver's license present as we process checks immediately. There is a $40 service charge for returned checks.

2. Office hours are by appointment only. As a courtesy to other patients, we request you arrive 15 minutes ahead of your appointment. If you arrive more than 10 minutes late, you may be asked to reschedule.

3. We specialize in Functional, Cosmetic and Integrative Medicine. As a specialty practice, all patients are expected to have a primary care physician to handle their routine and emergency medical care. We will not be available to you after normal business hours for sick calls, prescription refills or other general medical care.

4. For emergencies, call 911 or go to the local emergency room. For non-emergent issues that CANNOT wait until regular office hours, please call our office at 215-586-3304. There will be a charge for calls after business hours. Please see Fee Schedule.

5. Parents are expected to provide the Falcone Center staff with an appropriate telephone number where they can be reached for telephone consults.

6. We will not respond to email questions regarding a patient's health.

7. The staff at the Falcone Center will make two (2) attempts to call on the day of the scheduled consult. If you miss your appointment time, you will be charged the full amount for that missed appointment.

8. We schedule considerable blocks of time for your appointments. Cancellation of appointments less than 72 hours prior to appointment date will result in loss of the total appointment fee. Two (2) consecutive missed appointments or three (3) in one calendar year may result in the discharge from the practice.

- New Patients. We require credit card information for new patients (Visa, Mastercard or Amex) to ensure appointment time. If a new patient fails to call with 72 hours notice of cancellation or show for his/her scheduled appointment, he/she will be billed $500.

- Established Patients. If an established patient fails to call with 72 hours notice of cancellation or show for his/her appointment, he/she will be charged a minimum of $125 or the cost of the allotted appointment time.

9. Long distance children (Greater than 120 miles) are to be brought to the clinic on a quarterly basis during the first year of treatment unless otherwise specified by the health care provider. Failure to do so will result in discharge from the clinic. Allowances will be made during the winter months due to weather.

10. Patient update forms are to be sent to the clinic via email or US Mail delivery on a monthly basis. The form will be provided to you by the clinic staff.

11. Please check your prescriptions prior to your upcoming appointment. We prefer to renew prescriptions at the time of the visit to assure accuracy. All prescription requests are taken during regular office hours and filled within 3 working days. Controlled medications are not refilled over the phone at any time. If a prescription medication is not covered by insurance, it is the patient's responsibility to contact their insurance company to ask what "alternative medications" are covered.

12. Standard lab tests should be drawn seven (7) days prior to your appointment unless otherwise instructed. Specialty lab tests can take up to eight weeks for results. We ask that you schedule your tests at an appropriate time to ensure that we receive the results from the laboratories prior to your next visit.

13. You are entitled to your record; however, we do charge a processing fee of $25.00 and require fourteen days notice for record copying. Records requests must be submitted in writing.

14. All special letter requests require a two weeks notice. The processing fee for this service is $50-100 payable prior to sending the letter. We will not write letters of medical necessity for issues that are repeatedly rejected by insurance companies. The doctor will occasionally write a letter if they feel strongly that there may be a chance of reimbursement. When written, such a letter will be billed at the hourly rate and charged to the family.

15. Letters to attorneys will be charged at the doctor's hourly rate. A retainer fee for the estimated time it will take the doctor to write the letter must be paid in advance by the attorney's office or by the patient's family.

16. Legal cases will not be accepted.

17. Cases involving parental jurisdiction issues, where both parents do not agree in writing that they want the Falcone Center to treat their child using the biomedical approaches they use, will not be accepted to the practice.

18. Medicare and Medicaid patients cannot be accepted as patients unless they agree to be seen outside the system on a "private pay" arrangement. If they choose to be seen, they will need to sign an agreement stating they will not submit claims to Medicare or Medicaid and that they understand they are responsible for all payments at the time of services. The doctor is not a Medicare/Medicaid provider and does not use UPIN number.

19. It is important to understand that Dr. Falcone often orders diagnostic tests from specialty laboratories and uses numerous biomedical treatments, most of which do not qualify for insurance reimbursement.

Would you like to be added to our eblast list so that we can send you information regarding our monthly news and events? YES NO

- I hereby acknowledge that I have received a copy of the Notice of Privacy Practices

- I have received the Falcone Center OFFICE AND FINANCIAL POLICY 3 page documents and Fee Schedule. By signing this Office/Financial Policy, I agree that I have read and understand the terms of this policy.

Patient's Name_____

Patient Signature or Legal Guardian: _____

Print Name: _____Date: _____

Patient Signature or Legal Guardian: _____

Print Name: _____Date: _____