[Practice Name]
[Practice Address]
[Phone Number]
[Date]

To: [Patient Name]
[Patient Address]

Welcome to [Practice Name]

Dear [Patient Name],

We are honored that you have chosen us for your healthcare needs. Our goal is to provide you with high-quality, compassionate care as you navigate your health journey.

Please review the following practice policies. Your signature at the bottom indicates that you understand and agree to these terms.

1. Appointments and Cancellations

We value your time. If you need to cancel or reschedule, please notify us at least 24 hours in advance. Failure to do so may result in a missed appointment fee of $[Amount].

2. Medication Refills

Please request refills at least 3 business days before your medication runs out. We require an annual office visit to maintain long-term prescriptions.

3. Insurance and Payment

We accept Medicare and [Other Insurance Providers]. Co-payments and deductibles are due at the time of service. Please bring your current insurance card and a photo ID to every visit.

4. Communication and Support

If you have a caregiver or family member who assists with your medical decisions, please complete our HIPAA Authorization form so we may speak with them regarding your care.

5. After-Hours Care

For non-emergencies after hours, please call [Phone Number] to speak with our on-call service. In the event of a medical emergency, please dial 911 or go to the nearest emergency room.

Policy Agreement

I have read and understand the policies listed above. I agree to abide by these terms while receiving care at [Practice Name].

_____
Patient Signature (or Legal Representative)

_____
Date

Sincerely,
The Staff at [Practice Name]