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Office hours by appointment

Robert O. Detweiler, D.O.
Certified in Family Medicine

Michael T. Parke, D.O.
Certified in Family Medicine

Stephanie D. Shearer, D.O.
Certified in Family Medicine

Evan Kessler, D.O.
Certified in Family Medicine

Christine M. Sabatino, CRNP
Certified in Adult Health & Gerontology

Robert Davis, CRNP, DC
Certified in Adult Health

Wendy Brian, CRNP
Certified in Adult & Women's Health

Receipt of Privacy Practices & Statement of Financial Responsibility

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Detweiler Family Medicine & Associates, PC. Our notice provides information about how we may use and disclose medical information that we maintain about you. We encourage you to read our full notice. If you have any questions about our *Notice of Privacy Practices*, please contact our designated Privacy Officer, Michael J Brown, at 215-368-1900 or by mail at 1970 North Broad Street, Lansdale, PA 19446, Attention Michael J Brown, Privacy Officer.

In order to provide you with quality service at the best possible rates, we ask that patients agree to the following policy and sign below. Detweiler Family Medicine will provide a service to you as agreed. That service has value. We ask that all bills be paid within 30 days of receipt. If more time is needed to resolve an invoice, we ask that you advise us accordingly at the time service is provided. If a bill remains unpaid for greater than 75 days, we may place the account into collections. If the account is placed for collection, the account holder will be responsible for any and all collection fees, including legal fees. Please note that failure to pay co-pay at time of service will result in a billing fee of $18.00. Furthermore, returned checks will be subject to a $30.00 fee. Additionally, we reserve the right to charge a fee of $45.00 when a patient misses a scheduled appointment without notifying our office in advance.

Printed Name:________________________________Signature:____ Date:______________________

Patient, Parent, or Personal Representative

If other than the patient, specify relationship:____

Patient Communication Preferences

As our patient, we may need to communicate information to you pertinent to your health. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or others involved in your healthcare. Occasionally, Detweiler Family Medicine will need to communicate with you while you are not here in our office. We communicate with patients through two main methods: On the telephone and through our secure, online portal. Please indicate below your preferred method(s) of communication. Please indicate your contact information below.

I give permission to leave medical information pertaining to me, my dependant or child, at the numbers listed below:

Method	Yes	No	Preferred?	Tel# / Extension
Home				
Cell Phone				
Work Phone				
Email Address:				

[YES] - [NO] - Detweiler Family Medicine may provide me appointment reminders via text message. If I decline text messaging, I understand I will receive a recorded appointment reminder call at my preferred telephone number.

Whenever possible, we prefer to communicate non-urgent and routine matters, such as normal lab results, through our **Secure Online Portal**. Please indicate below your communications preferences with our office:

[ ] - Please communicate non-urgent matters (*e.g., appointment reminders, normal lab results, routine medical reminders, prescription confirmations*) to me through the **Secure Online Portal**. When you need to reach me over the phone, please do so at the telephone number indicated above as preferred.

[ ] - I prefer to customize by communications preferences as follows: Use reserve side of form if more room is needed.

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Without permission, we will not release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e., spouse, parent, partner, etc.):

Name	Relationship	Tel# / Extension

I acknowledge that I am responsible to inform the practice of changes pertaining to my contact information and communication preferences. If I so desire, I may revoke this specific medical information authorization at anytime.

Printed Name:________________________________Signature:____ Date:______________________

Patient, Parent, or Personal Representative

If other than the patient, specify relationship:____