Office Policies

Copays, Deductibles and Co-insurance
Depending on your insurance plan, you may be responsible for copay, co-insurance and/or deductible for the services we provide. Due to contracts with the insurance plans we participate with, we must collect ALL copay, co-insurance and deductibles at the time of service. We make every effort to verify benefits on all patients and notify patients of their financial responsibility prior to rendering service, but ultimately it is the patients’ responsibility to know their insurance requirements. This is a no exception policy. If you require financial assistance, please notify the office manager.

If you change insurance, it is your responsibility to notify the office immediately.

Appointments
If you have a scheduled appointment, we ask that you please notify our office as soon as possible prior to your appointment to cancel if you are unable to make your designated time. There are many patients that need those appointments, so please, as a courtesy to others, make sure you cancel. After the third instance of not cancelling and not showing for an appointment, you may be discharged from the clinic for non-compliance.

Prescriptions, FMLA/Disability Paperwork, Nurse Calls
If a prescription refill is needed on a medication that was prescribed by our physician, please call your pharmacy and have a refill request faxed to our office at 214-483-6933. You must allow 72 hours for refills to be processed. Only prescriptions that are prescribed by our physician will be refilled. Please refer to your original prescribing physician for all other medications. We also participate in E-prescribe and requests may be forwarded that way as well.

There is a charge of $25.00 dollars for the completion of FMLA or disability forms. Please note that these forms are filled out by the physician or the R.N., so we ask that you allow 4-5 business days for the completion of these forms.

If you call with questions for the nurse, please leave a detailed message either with the front office staff or on their voicemail and the nurse will call you back at the end of the day. All calls received after 4 p.m. will be returned the next business day. If you have an emergency, please call 911 or go to your nearest emergency room.

Physician Phone Calls
Many times, patients want to call and speak with the physician to ask additional questions about their condition. Due to the physician’s office schedule and to not take time away from the patients in the office, these calls will be directed to the appropriate Medical Assistant for triage. The M.A. is able to ascertain how your call should be routed. If you feel that after speaking with the M.A. you would still like to speak with the physician, we ask that you schedule an office visit.

If you have an after hours emergency, please call the office and the answering service will page the physician.
Scheduling of out patient testing
The physician will often order tests that need to be conducted at separate facilities. We will schedule your test and obtain preauthorization if required. However, we will only schedule on your behalf once. If you find the time and date of the test or procedure does not work with your schedule, we will provide you with the phone number of the facility and you may reschedule for a time that is more convenient.

Results
If the physician has ordered tests for you, please schedule a follow up appointment to discuss the results. Test results are not released to anyone until the physician has reviewed the results and discussed them in the office with the patient. Test results are not given over the phone.

Medical Records
In order to release medical records, we must have a current signed Release of Information form. Please note that there is a $25.00 dollar fee for the duplication of medical records up to the first 50 pages then $0.50 per page thereafter that must be paid before the records will be released. Please allow 5-7 business days for completion of your request.

We appreciate your cooperation with these policies. These policies are put in place to provide structure so that we can better serve every one of our patients. If you have any questions regarding these policies, please address them with the Practice Manager and she will be happy to discuss them with you.

We look forward to serving your hematologic and oncologic needs.

Thank you,

The Staff at the Plano Cancer Institute
Acknowledgement of Receipt Patient Policies

I have read and understand the office policies of Plano Cancer Institute as outlined in the previous pages. I also understand that PCI reserves the right to modify the policies as necessary without prior notification.

_________________________________________________
Name of Patient (Print)

_________________________________________________
Signature of Patient

_________________________________________________
Date of Patient Signature

_________________________________________________
Signature of Patient Representative
(Required if signing on behalf of a patient who is unable to sign)
Patient Pharmacy Information

Patient Name____________________________    DOB________________________

Preferred Pharmacy ____________________ Pharmacy Phone #______________

Pharmacy Address_____________________________________________________
______________________________________________________________________

History Download Consent

I understand that the Plano Cancer Institute is participating with the E-prescribe program. I understand that if my pharmacy is participating with the program then the Plano Cancer Institute will electronically submit my prescriptions to the pharmacy. I understand that with this program, it is possible for my medication history to be submitted electronically from my pharmacy to my electronic health record with my expressed permission. I understand that this information will only be used in conjunction with my medical care.

_____ I give permission to Plano Cancer Institute to obtain my medication history from my pharmacy.

_____ I do not give permission to Plano Cancer Institute to obtain my medication history from my pharmacy.

____________________________                                   ________________________
Patient or Representative Signature         Date

____________________________                                   ________________________
Staff Member/Witness                                                        Date

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Suite 2500  
Plano, TX 75093  

7777 Forest Ln.  
Suite C-204  
Dallas, TX 75230

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