

IRINA FELDMAN MD INC.
351 Rolling Oaks Drive, Suite 204
Thousand Oaks, CA 91361
[Tel: 805-777-7676](tel:805-777-7676)
Fax: 805-777-7680

OFFICE POLICIES FOR OUR PATIENTS

Thank you for choosing Irina Feldman MD as your provider. We recognize that you have a choice in medical providers and are pleased that you put trust in our practice. Our office strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality and timely medical care by creating strong doctor-patient relationship and collaboration. In order to do so we have implemented office policies. The practice reserves the rights, with or without notice, to change, add to or delete any of the policies, terms, conditions and language presented.

Office Hours

Our office is open Monday-Thursday from 9 am to 4pm and Fridays from 9 am to 12:30pm. Office is closed on Saturday and Sunday. Please call the office to schedule an appointment or contact us for non-urgent matters through the practice portal for faster and more efficient response.

Appointments

We are committed to providing quality care to our patients. When calling for an appointment please provide your name, date of birth, a reason for the visit, as well as any updated insurance information. We try to accommodate established patients with acute visits on the same day or at least the same week when possible. Please do not be late and come 15 min earlier prior to your Wellness visit.

Cancellation of an Appointment

Please give the office at least 24h advanced notice about rescheduling or canceling your appointment as a courtesy to other patients and our staff. Cancellation fee \$35.

No Show Policy

A failure to present at the time of the scheduled appointment will be recorded in your medical chart as a “no-show”. An administrative fee of \$35 will be charged to your account. Three (3) “no-shows” within one (1) calendar year may lead to patient termination from the practice.

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Insurance

Our office is contracted with most major PPO health insurance plans. It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could result in delay or denial of insurance payment.

Patients are responsible for all co-pays at the time of service. You might be billed for services not covered by your insurance if applicable.

Payments

Our office accepts cash, personal checks, MasterCard, Discover, and Visa. We do not accept American Express. Checks can be made out to Irina Feldman MD. It is our office policy to make all reasonable attempts to collect outstanding balances should they accrue including convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

Forms/Letters

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. Our office will be happy to complete forms and write medical letters as necessary upon your request. Please allow 7-10 days for completion of requested forms/letters, charges may apply.

Medical Records

Medical records are confidential and are only released when permitted by law or with proper written authorization by the patient. Upon request, medical records are released in a timely manner to the patient or the patient's representative.

Prescription Refills & Pharmacy Information

Please make sure that our office always has your current pharmacy on file and allow at least 48 hours for refill requests. If you have not seen the physician in **3-6 months** your prescription will not be refilled. We encourage our patients to review their medications prior to their office appointments and to request refills at that time.

All controlled substances and pain prescriptions require doctor's visit on a regular basis.

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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and Address of Patient: _____
