Marchand & Associates
FAMILY MEDICINE

4534 Westgate Blvd., Suite 113 • Austin, TX 78745

In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

- I understand the clinic normally uses Clinical Pathology Laboratories (CPL). If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is being taken so I am not billed for having lab work processed by CPL, instead of another lab.
- I understand there can be a fee for controlled substance prescriptions written without an appointment.
- I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you cannot make your scheduled appointment.
- I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 days to be completed.
- I understand prescription renewals are to be processed through the requested pharmacy. If the prescription is mail order and requires a written prescription, it may take 3-4 business days to be processed.
- I understand that labs, x-ray reports, and other test results need to be reviewed and it may take between 3-4 business days to be reviewed by the physician/PA. A staff member will contact you sooner if the results are urgent; otherwise, you will be contacted by phone, mail or via our secure patient web portal with the results.

Fees for Services:

$12 Controlled substance prescriptions without an appointment
$15 Transfer of entire medical record, notary service, school forms with an appointment, disability forms
$25 Medical Records (purpose of life/medical insurance, attorney requests)
$35 Attending physician statement
$50 Physician dictated letter
$75 Physician narrative
$20 Collection Fee

Thank you for your cooperation.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Patient Signature Date

CONSENT TO GIVE TEST RESULTS

Patient: _____ Date of Birth: _____

I give permission to allow Marchand & Associates Family Medicine to leave results of

_____ Blood Tests

_____ X-rays

_____ Cultures, including throat, urine and genital

_____ All of the above

on or with

_____ Myself only

_____ My spouse or significant other (Name _____)

_____ Other family member (Name _____)

_____ On home answering machine or cell phone # _____

_____ On office/work voice mail # _____

I also give permission to receive all results by mail to address:

_____

_____

Signature: _____ Date: _____

GREGORY MARCHAND, M.D.