LANDMARK MD

David A. Layne, MD
100 North Main Street
Suite 150
Belmont, NC 28012
Tax ID: 47-2617274
NPI: 1720045958
Phone: 704-461-8111 Fax: 980-819-4672 After Hours Calls: 980-206-0060
Email: davidlaynemd@gmail.com

Patient Financial and Medication Policies

In order to provide a more personalized level of service, Landmark MD and other Direct Primary Care practices have a different business model than traditional primary care offices. We have no dedicated billing department, which allows us to keep our fees affordable for our patients. In addition, government regulations have impacted all health care providers and we must follow their guidelines when prescribing medications and providing patient care.

- All patients MUST have a credit card, debit card or checking account on file if they are on the monthly payment plan. We do accept cash payments; however, we must have the ability to draft payments in the event that patients cannot come into the office to pay their membership fees in a timely manner. **This card/account MUST be in the patient's name unless it is a joint account, and if not, we need written permission from that person to process payments to that card/account**.
  _____ (initials)
- There is a mandatory 3-month minimum membership term for all new members. Early termination will result in the remainder of the 90-day term billed to the card/account on file at the time of termination. Patients paying with cash must pay the entire 90-day membership fees at their first visit. _____ (initials)
- Membership rates are as follows: Patients age 40 and up: $85/month. Patients under age 40: $70/month. Dependent children up to age 26: $30/month (MUST have a parent as a member to qualify for rate). Family maximum: $180/$200month (includes both parents under age 40 /children, NOT additional adult family members. Family maximum with one/both parents age 40 and older, $200/month). _____ (initials)
- If your account is more than 60 days past due, maintenance medication refills may be denied. We will make every attempt to contact you in order to bring your account current or to set up an approved payment arrangement. _____ (initials)
- Patients are subject to dismissal from the practice if their account is 90 days past due. If you are dismissed from the practice, reinstatement is upon Dr. Layne's discretion and a $240 reinstatement fee PLUS payment of entire past due balance is required before an appointment can be made. _____ (initials)

Controlled Medication Policies

- NO controlled substance medications will be refilled if your account is greater than 30 days behind. There will be no exceptions to this policy. _____ (initials)
- ALL patients on controlled medications MUST be seen at least once every six (6) months in order to continue receiving medications. We are required to maintain current office notes on ALL patients who are receiving controlled medication prescriptions. _____ (initials)
- All patients who are on monthly narcotic pain medications will be required to sign a pain management agreement indicating their understanding of proper medication rules and regulations including early refills, lost/stolen prescriptions and obtaining narcotic medications from other providers. _____ (initials)
- In the event that a patient receives an injection for pain, there will be a fee assessed as stated in the pain management agreement. This fee is not included as part of the monthly membership agreement. _____ (initials)
- Due to new regulations by the DEA and changes in healthcare accountability, ALL patients who are prescribed controlled medications are subject to random urine drug screens. This is not only to protect our patients but also to protect our staff. These drug screens are not included in the monthly membership fee and must be paid by the patient. The fee for this testing is $40.00. If you do not agree with this policy, we will be happy to refer you to a provider of your choice. _____ (initials)

We realize that financial emergencies occur, and we are willing to work with you to establish payment arrangements if we are aware of your difficulty. Thank you for your understanding.

By signing below, I acknowledge the Landmark MD Patient Financial and Medication Policy:

Name (print) _____

Signature _____ Date _____/_____/_____