

Plaza Medical Centre

700 N Pearl St, Suite N208
Dallas, TX 75201
Tel: (214) 999-9355



Griego Family Medical Centre

2701 S Hampton Rd, Suite 101
Dallas, TX 75224
Tel: (214) 330-9221

OFFICE POLICIES & CONTACT PERMISSION

OFFICE POLICIES:

Because we are subject to the increasing demands of managed care, it has become necessary to alter our office policies. Our office policies are as follows:

1. **No Results given over the phone.** We value our patients and to give the best care possible, we prefer our patients follow up on all abnormal results. This is required to ensure that patients understand the results and to discuss further treatment and do the necessary diagnostic test. Abnormal results cannot be given over the phone.
2. **Return phone calls.** As our providers see numerous patients during the day, it is very difficult for them to return phone calls during regularly scheduled hours. We ask that you allow up to 24 hours for us to return your phone calls with the exception of emergencies. In addition, we do not bill for any phone calls as it is a courtesy to our patients. **If you are experiencing a life-threatening situation, please call the emergency room for immediate assessment.**
3. **Late arrivals.** Patients that arrive late for their scheduled appointment will be seen as soon as possible. However, should another patient with a scheduled appointment arrive at the same time, they will be seen first.
4. **We file insurance** as a contractual agreement and as a courtesy. However, if we do not receive payment from the insurance company within 90 days, it then becomes the patient’s responsibility, and the patient will be billed.

CONTACT PERMISSION:

In order to provide future appointment confirmations, office appointments, newsletters, educational articles, and/or other information from Metroplex Medical Centres, we would like permission to use your email and/or your cellular telephone number.

I understand that the above information will be kept private and confidential, and I give permission for Metroplex Medical Centres to email and/or text me as needed.

Patient Name: _____ **Date of Birth:** _____

Email Address: _____ **Cell Phone:** _____

Patient Signature: _____

I have read and understand the policies described above.

Patient Signature: _____ **Date:** _____