

**LAKE PULMONARY ASSOCIATES**  
**GARY B. KAPLAN, M.D., F.C.C.P.**  
**RUSSELL A. BLAIR, M.D.**  
**ANDRE M. FABIEN, M.D.**  
**LISA A. KUHEN, MSN, APRN-BC, CNP**  
*Practice of Pulmonary and Critical Care Medicine*

Welcome to our practice. Thank you for choosing our office for your health care needs. We are committed to helping you receive the highest quality medical care possible and believe this is achieved through open honest communication between the patient and health care providers. You play a vital role in your health maintenance and we will make every effort to keep you informed so we can work together to help you achieve your optimum level of health.

The following information outlines the day to day office policies and answers to frequently asked questions about our practice.

**APPOINTMENTS:** Can be made by calling the office Monday thru Friday from 9:00 AM-5:00PM.

If you are not feeling well, every effort will be made to see you in the office within 24hours. However, for all life threatening emergencies you are directed to immediately call 911.

**PLEASE BRING A LIST OF ALL YOUR CURRENT MEDICATIONS TO EACH VISIT.**

**PRESCRIPTION REFILLS:** Please ask for prescription refills at your visit. Specify 30 day or 90 day fills. If a refill is needed in between visits, please ask your pharmacy to fax a refill request to our office or you may pick up a written prescription at our office within 48hours of your call with the exception of weekends and holidays. We are unable to refill prescriptions on weekends and holidays.

**PLEASE BE AWARE WE ARE UNABLE TO REFILL PRESCRIPTIONS IF YOU HAVE NOT BEEN SEEN IN THE OFFICE IN THE LAST CALENDAR YEAR.**

**TELEPHONE CALLS:** Please don't hesitate to call the office during business hours with medical questions or concerns. Every effort is made to return calls by the end of the day.

**FEES AND INSURANCE:** Our fees for professional services are based on the established usual and customary charges. We will be happy to discuss with you any questions you may have regarding fees. If financial difficulties arise, please call our billing office to discuss assistance.

**CO-PAYMENT IS REQUIRED AT THE TIME OF YOUR VISIT**

**CANCELLATION POLICY:** If you are unable to keep your scheduled appointment a 24hour cancellation notice is required. Failure to cancel an appointment will result in a \$25.00 charge and require a security deposit of \$25.00 to reschedule.

I have reviewed the above office policies and understand that failure to cancel an appointment will result in the above fees which are my financial responsibility.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness to Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_