Appendix A:

Informing Patients of Change in Office Policy (Sample Letter)

<Insert physician name(s), office/clinic logo and address, other contact information and date>

Dear Patient:

This letter is to notify you of changes in our office policy. For your information, OHIP does not pay for all services that you request from your physician(s). Services that OHIP does not pay for are called “uninsured services” and it is illegal and fraudulent for physicians to bill OHIP for them. Effective <insert date>, this office will implement an Uninsured Services Program.

Every effort has been made to account for most of the commonly requested uninsured services in the attached information sheet. If the uninsured service you are requesting is not listed, please communicate this to me or the office staff for further clarification. To help speed up our service, please let my office staff know when you are making your appointment that you are requesting a service that is on the attached list or a service for which you have been charged in the past by this office or another physician’s office.

The fees contained in the attached list are in accordance with the <insert appropriate year> edition of the *OMA Physician’s Guide to Uninsured Services*. Note that you have the option of paying for each service as it is rendered or you can elect the block fee option, which is an annual fee for an unlimited number of the services listed. You will receive an enrolment form shortly, and you will be asked to indicate your preferred option.

All uninsured services must be paid in full when rendered; office staff will provide a receipt upon settlement of your account. Should you be unable to pay for the uninsured service at the time it is provided, please let my office staff know when and how you intend to settle your outstanding account. We will make every effort possible to assist you in the settlement of your outstanding account. Please note that our office accepts <insert payment methods> payments.

Please acknowledge receipt and acceptance of the above office policy by signing below and returning the detachable portion by either fax, mail or in person to my office. Alternatively, you can deliver your acceptance via email to <insert email address>. Should you have any further questions, please contact <insert name of office staff person> at my office phone number.

Sincerely

<insert name and signature>

(Enclosed: Uninsured services offered and associated fees)

I agree with the above policy and terms/conditions.

Patient Name Patient Signature Date signed

Ontario Medical Association