Acknowledgement of Receipt of Notice of Privacy Practice

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Patient Name _____

Patient Signature _____

Relationship (if not signed by patient) _____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to the patient and sign below:

Presented on (date and time) _____

By (name and title) _____

MISSED APPOINTMENT FEE

There will be a fee of $25.00 for missed appointments. I understand that if I should fail to keep my appointment or fail to call to reschedule, I will be charged a fee of $25.00.

Name: _____Date:_____

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between out-patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Visa, MasterCard, cash, and personal checks.

Your Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- I understand that I will be legally responsible for all collection costs involved with the collection of this account if I default on this agreement.

Minor Patients:

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____

(Printed Name of Patient) (Date)

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(Signature of Patient or Responsible Party if Patient is a Minor)