HIPAA Notice of Privacy Practices

____ Check here if you DO NOT want your health care information discussed with anyone other than yourself.

Please list below those individuals with whom we can leave a message or briefly discuss your medical information. This person(s) will also be able to call the office on your behalf. Please list any additional person(s) on the back of this form.

Name_____ Relationship_____ Phone #_____

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I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Signature of Patient/Guardian_____ Date_____

Printed name of Patient _____ Witness _____

Financial Policy

* Payment for Office visits and X-rays are due **IN FULL** if you DO NOT have insurance. If you have insurance, we will file a claim for you as a courtesy to our patients.

* **YOU are responsible** for any balance in full after 90 days if your insurance has not paid yet unless otherwise agreed upon.

* Payment for services for minor children (17 years old or younger) is the responsibility of the **person who signs this form**.

* There will be a $25 fee for NSF checks returned to us.

* Delinquent accounts will be transferred to a collection agency and a **$20.00** charge will be added to the account charges.

* If your account balance is over **$550** we **CANNOT** schedule further appointments until an arrangement has been made.

Signature of Patient/Guardian _____ Date_____

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