PATIENT CONSENT FORM

The Privacy Rule was created in order to provide a standard for health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records. We strive to achieve a high standard of ethics and integrity in performing services for our patients. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____ _____/_____/____
Print Name Date

_____
Signature

PAYMENT POLICY

It is our intent to deliver the best in medical care. This entails prompt payment for our services, so please note our office policies:

1. All co-payments and non-covered items are to be paid at the time of visit and before services are rendered.

2. You are responsible for payment of all charges, including any balance due following insurance payment.

3. If you are a Medicare Patient, when you receive services that are not benefits of Medicare, you are responsible to pay for them personally. I understand and agree to the terms set forth above.

_____ ____/____/____
Print Name Date

_____
Signature

CANCELLATION & LATE POLICY

Your appointment time is reserved specifically for you. If you are late for your appointment, we may not be able to accommodate you. If you think you may miss or be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated or if there will be a need to reschedule. Multiple missed appointments may result in patient dismissal.

_____ ____/____/____
Print Name Date

_____
Signature