ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

Federal law requires that we seek your acknowledgment of the Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of September 14, 2008, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: ______________________________________ Date: __________________

Printed Name: ____

Signature of Parent/Guardian(if patient is a minor):

____ Date: ____________

ACKNOWLEDGEMENT OF CANCELLATION/ NO SHOW POLICY

In order to be respectful of the medical needs of our patients, we have incorporated a cancellation/no show policy. Please read the following carefully, then sign that you have been informed of the policy.

If it is necessary to cancel/reschedule your appointment, we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

A “no show” is someone who missed an appointment without cancelling 24 hours in advance. A failure to present at the time of a scheduled appointment will be recorded in the patients’ chart as a “no show”. An administrative fee of $25.00 will be billed to the patient account.

We value our patient relationships and will do everything we can to accommodate you. Your communication and compliancy are not only very much appreciated but will help us to help you (and others) achieve a positive outcome.

I acknowledge that I have been informed of the Cancellation/No Show Policy.

Signature: ______________________________________ Date: __________________

Printed Name: ____

Signature of Parent/Guardian(if patient is a minor):

____ Date: ____________