

**ACKNOWLEDGEMENT  
OF  
PRIVACY PRACTICES**

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Office Use Only:**

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

**To Our Patients:**

It has become necessary to put our office policy in writing. Payment is due when services are rendered. This keeps our office expenses down; and in turn keeps our fees down. We accept cash, check Mastercard, Visa or Discover.

**Regarding Appointments:**

Our office policy is to charge a cancellation fee for a short notice cancellation or no show appointment. We require **2 business days** notice to avoid this fee. I hereby accept responsibility for any charge made necessary by failing to keep my appointment.

Signed: \_\_\_\_\_

**Regarding Insurance:**

If your care is to be paid through an insurance program you must have all pertinent information with you at the time of your appointment. Due to the number of types of programs in use, it is impossible for us to tell what your program covers. Individual programs change from year to year, and often from patient to patient. You, the subscriber, have an information booklet which explains the extent of your coverage. **In all cases the responsibility for determining whether or not you are eligible for benefits rests on you.** If we are unable to confirm benefits, or obtain a fee schedule (if applicable), you may be asked to pay for your services, in full, as they are rendered and you will be reimbursed from your insurance carrier. If this is the case, we will be happy to process the forms for you at no additional charge.

*I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered. If my insurance denies payment or there is an unpaid balance, this amount becomes my responsibility and the balance is due within 30 days. I have read all the above information and have hereby released this information to the appropriate party or doctor.*

Signed \_\_\_\_\_ Date \_\_\_\_\_

*If signing for a minor, relationship to minor* \_\_\_\_\_