

that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature below authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Responsible Party Signature

Relationship

Date

Cancellation Policy

Please be courteous, if you are unable to attend your scheduled appointment; kindly give us 24 hours notice. If you fail to show for your scheduled appointment, you will be charged a 35.00 fee.

My signature below confirms my acknowledgment of this policy.

Signature

Date

Privacy Practices Acknowledgement

Your personal information will only be provided to:

- ❖ Your insurance company
- ❖ Your primary care physician
- ❖ Any specialists that you have been referred to by our office
- ❖ Any tests that we schedule for you

This will only be done as necessary.

Name: _____

Signature: _____ Date: _____