Acknowledgement Form

Privacy Practices

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

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Signature of Patient, Parent, Guardian or Personal Representative Date

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Please Print name of Patient, Parent, Guardian or Personal Representative Relationship To Patient

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the Patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. For a past due account, if the balance goes to collection, patient is responsible for collection fee and lawyer fee.

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Signature of Patient, Parent, Guardian or Personal Representative Date

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Please Print name of Patient, Parent, Guardian or Personal Representative Relationship To Patient

Cancellation Agreement

I acknowledge that in case of a Cancellation, I have to give 24 hour notice prior to my appointment to avoid a $50.00 service fee. I accept full financial responsibility for the cancellation fee, for myself, my minor/child, or to the patient for whom I have legal responsibility.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please Print name of Patient, Parent, Guardian or Personal Representative Relationship To Patient