

Please READ & SIGN the following Notice and Agreement

1. HIPAA: Notice of Privacy

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving your office my permission to use and disclose my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand I have the right to revoke permission.

1. SIGNATURE



2. FINANCIAL AGREEMENT

For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at the time.

If sent to collections, I agree to pay all related fees.

Every effort will be made to help me with my insurance, but if they DO NOT PAY as expected, I WILL BE RESPONSIBLE FOR ALL FEES FOR TREATMENT.

Treatment plans may change, I will be informed and I will be responsible for the treatment that is done.

I AGREE ALL FEES ARE DUE AT TIME OF TREATMENT.

2. SIGNATURE
