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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please print Name: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify)

SELF PAYMENT POLICY

Charges for services including the consultation fee are due in full at the time of service.

Surgical Services

Elective and cosmetic services must be paid in full with cash or a cashier's check at least 14 days before the scheduled date of service. If payment is not received two weeks prior to surgery, the procedure will be cancelled.

Collection Agency

Each account that is not paid in accordance with our payment policy is subject for review with our collection agency and the debtor will be charged for related collection costs.

Agreement

I have received a copy of this document today and agree to its terms and conditions for treatment.

Signature: _____ Date: _____

Your electronic signature on this form is your legal signature signifying that you understand what has been presented to/discussed with you and you have given your informed consent to the policies.