Acknowledgement and Requested Restrictions

This form is provided to you at registration and subsequently annually. By signing this form, you acknowledge that you have reviewed this Notice of Practices prior to any services being provided to you by the practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated on the Acknowledgement and Requested below.

* A copy of the Notice of Practices is available at the front desk of this office.

Acknowledgement and Requested Restrictions or Use are completed, signed and filed in patient's charts.

***We do not release information to anyone who is not involved in your healthcare.**

USE: Please list the name of any people whom we may inform about your health care information:

* _____

If you would like postcards and/or correspondence from our office sent to an address other than you home address, please list it below:

_____

If you would like to receive calls regarding your health information at a number other than your home number, please list it below:

(_____) _____

* I am fully aware that a cell phone is not a secure and private line.

If we call and you do not answer, and you have an answering machine or voicemail that is setup, can messages (i.e. appointment reminders) be left on your machine or voicemail? We will not leave messages pertaining to your diagnosis or other confidential information. * If you mark "NO" we are not able to leave you messages about your upcoming appointments or lab results.

Please check one: YES _____ NO _____ NO MACHINE/VOICEMAIL _____

We have a 24 hour cancellation and no-show policy and you will be subject to a fee of $25.00 for a no-show or late office visit cancellation and $100.00 fee for a no show or late surgery cancellation. This fee will not be covered by your insurance company.

* Patient Name: _____ Date of Birth: _____

Signature/Legal Representative: _____

Date: _____ Relationship (if Legal Representative): _____