



Patient's Responsibility
Bill of Rights and Disclosure Agreement

- I agree to be on time for my appointment and I understand I may be billed for any appointments missed if I fail to notify the office 48 hours in advance.
- I understand payment is due at time of service and I agree to pay my payment/co-payment at the time of my appointment.
- If I fail to pay my bill in a satisfactory manner I realize I may not be allowed to have future office visits until the balance is paid.
- I understand that the office can only bill for a service documented in my record and ask the doctor/office to change the diagnostic code to secure insurance payment constitutes fraud.
- I will make every effort to understand the benefits of my insurance plan, even to the extent of calling the carrier or the benefits coordinator at my place of employment. I understand I am responsible for payment of services I receive, including services not covered by my insurance.
 - My records will be held in strict confidence and for anything other than treatment, payment or healthcare operations, will not be released without my written notification or authorization.
 - I can best be reached at home # _____ office # _____
cell # _____
- The office may _____ leave a call back number or _____ leave a message.
- The office may send a text to : _____ and/or email to: _____
- If you would like us to be able to discuss your treatment with another party, please state below:
_____ DO NOT discuss treatment with anyone but me
_____ You can discuss treatment with _____
- I understand I have been offered a Notice of Privacy Policy that provides a more complete description of protected healthcare information uses and disclosures. A revised copy of notice can be obtained in our office.
- By signing this form, I fully understand and accept the terms of this agreement.

Signed _____ Date _____