Patient Name _____ Date of Birth _____
(Last, First, Middle)

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). You may also obtain a copy at the front desk or contacting the Main number at (540) 252-1840.

_____ _____
Patient/Legal Representative Signature Date

Staff Use Only *(check box):* ☐ NOPP Offered Pt Declined to Sign

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ASSIGNMENTS OF BENEFITS

Financial Waiver/Policy

I hereby assign medical and/or surgical payments to include major medical benefits to which I am entitled, private insurance and any other health plan to The Children's Clinic of Fredericksburg for services provided by its providers and staff.

By signing this document (below), I understand if claims are denied due to eligibility status, invalid medical group or invalid Primary Care Physician (PCP), I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be held financially responsible for any non-covered benefits, deductibles or any co-payments for services, which have been provided to me. We always recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage. We typically submit our office specimens to The Children's Clinic of Fredericksburg Laboratories/LabCorp unless specifically requested at the time of service of every visit.
It is my responsibility to understand my insurance benefits and plan coverage.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

OTHER FINANCIAL POLICIES

Release of Information for Reimbursement

To the extent necessary to obtain reimbursement, the physician's office may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the physicians charges, including but not limited to, insurance companies, healthcare service plans, workers' compensation carriers, social security administration and peer review organizations. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Late / Cancellations / Appointment No Shows

We understand life happens. We will waive the cancellation fee for your *first* missed appointment. **Subsequent missed/no show appointments will be charged a $25. fee.** After 15 minutes late, we will update your appointment to "walk in" status and you may be subject to a waiting period. It is within the physician's discretion to dismiss you from the practice if you've had repeated cancellations or no-show appointments.

Charges for Completion of Forms and Photo Copying Medical Records:

There is a charge for completion of forms and photo copying of medical records.

Payment Method:

For your convenience, we accept VISA, MasterCard, Discover Card, personal checks and cash. *Please make your check payable to The Children's Clinic of Fredericksburg*. There will be a charge for returned checks.

By signing this document, I understand and agree with the Assignments of Benefits and Other Financial Policies listed above.

_____ _____
Patient /Legal Representative Signature Date