Heritage
FAMILY HEALTH, PC

ACKNOWLEDGEMENT FORM

Patient Name: _____ **DOB:** _____

Policy of Payment:

* I certify that I (or my dependent) am financially responsible for all charges at this cash-only/direct-pay practice at the time of each visit. If I have insurance, I will receive both a receipt of payment and a form detailing my visit which I can submit to my insurance carrier for direct reimbursement (if policy allows). Payment can be by cash, check, or credit/debit card.

Acknowledgement of Receipt of Privacy Notice (HIPAA):

* My signature acknowledges that Heritage Family Health, PC has offered or given me a copy of its Privacy Notice, which explains how my health information will be handled.

Consent for Treatment:

* Having voluntarily placed myself (or my dependent) under the care of Heritage Family Health, PC, I acknowledge that the evaluation and treatment received from Heritage Family Health, PC is a mutual partnership between myself and the Physician.

Consent for Disclosure of Personal Medical Information:

* As a patient, I agree to let certain individuals participate in discussions and decisions related to my medical care. Those who are age 18 or older may pick up medical forms/prescriptions in my absence when necessary.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Patient/Guarantor Signature: _____**Date:** _____

By signing above, I indicate that I have fully read & acknowledge/understand each section above as indicated by an asterisk (*).