Longs Peak Family Practice

POLICY SIGNATURE PAGE

Name: _____DOB: _____ Date: _____

I have read and understand **the Longs Peak Family Practice's Financial Policy**. I understand that I will owe a co pay/co-ins/deductible at every visit, unless my insurance pays in full for all services. Failure to pay the co pay/co-ins/deductible within 60 days will result in a $25 finance charge. I also understand that all outstanding/previous balances are due upon receipt of any statement and/or should be paid in full at my next visit or within 60 days, whichever comes first. If I am unable to pay my balance in full by 60 days, I will arrange a payment plan that will resolve my debt within 90 days of agreement date.

Patient Signature: _____

I have read and understand **the Longs Peak Family the PE/Physical Wavier** and understand that there may be a co pay/co-ins/deductible added for additional issues that fall outside of the annual physical. We often look at chronic/acute problems such as high blood pressure, arthritis, and/or other ongoing medical conditions, though we don't always charge for that, depending on the degree of difficulty or amount of time spent that could be cause for an additional charge. Other examples that can cause additional charges: **If I have any questions, I will ask my provider.**

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name: _____

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason: