I HAVE READ AND UNDERSTAND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND HEREBY AUTHORIZED SUPERSTITION FAMILY MEDICINE TO RELEASE HIPAA INFORMATION IN ACCORDANCE WITH GUIDELINES, EXCEPT AS SPECIFICALLY NOTED. A COPY OF THOSE GUIDELINES/PRIVACY POLICY IS AVAILABLE TO ME ONLINE AND HAS BEEN OFFERED TO ME AT HTTPS://SUPERSTITIONFAMILY.COM.

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE VISITS & PAYMENT POLICY**

Thank you for choosing us as your care provider. Please review our office and payment policies.

**Cancellations:** We ask that you give us at least a 24-hour notice if you will not be able to keep your appointment. Please understand that when we schedule your appointment, we are reserving time for your specific needs and your records are prepared. Not showing up for an appointment or canceling less than 24 hours prevents us from helping other patients in need. We just ask for you to be mindful and courteous. We only charge a cancelation fee of $50 when you schedule to be seen in-office on Saturday and do not show up.

**Late Arrivals:**  We just ask that you call and inform us that you will be late. We understand that life happens and no one can control the weather.

**Identification:** We must obtain your ID card (example driver’s license) All patients must complete our patient information forms to consent for treatment.

**Insurance:** We will no longer accept insurance for payment as of 2/1/2024. We have moved to concierge services which payment is due at the time of service or as scheduled (i.e. withdrawn from your checking account or charged to your credit card as a monthly charge).

**Non-payment:** If you have a balance due on your account, we will notify you by phone, mail, and/or at your next office visit. Balances are expected to be paid in full unless otherwise discussed with our billing department. Your provider will not discuss covered services, payments or balances with patients, as they concentrate their efforts on your health care. If payment is not made, the balance due will be sent to a collection agency for continued collection efforts and possible dismissal from our office. Our practice is committed to providing excellent treatment to our patients. Thank you for understanding our office and payment policies. I have read and understood the office and payment policies.

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 **Signature of patient or responsible party** **Date**

**Acknowledgement of Payment Policy and Privacy Rights (HIPAA)**

**Superstition Family Medicine**

**Make Primary Care Great Again!**



