Flower Mound Family Physicians acknowledgement of receipt of Financial Policy Agreement.

By signing below, I acknowledge that I have received a copy and have read the Financial Policy Agreement for Flower Mound Family Physicians.

I permit Flower Mound Family Physicians to release any information deemed necessary to any insurance company or third party, within the guidelines of HIPPA (Health Insurance portability & Accountability Act of 1996)

_____ ___/___/___
Patient Name Date of Birth

_____ _____/_____/_____
Signature of patient or patients legal representative Date Signed

_____
Print Name and relationship to patient

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For Office Use Only (for forms not completed)

I _____ made a good faith effort to obtain written acknowledgement of _____'s receipt of the Financial Policy Agreement for Flower Mound Family Physicians, however I could not obtain written acknowledgement due to the following:

1.) Individual refused to sign the acknowledgement.

2.) Patient is a minor and is not accompanied by an guardian.

3.) Communication barrier prohibited obtaining a written acknowledgement.

4.) An emergency situation prevented me from obtaining a written acknowledgement.