Practice: **Medical Partners of Nevada** **Today's Date:** _____

Name:_____ **DOB:**_____
Sex: ☐ M ☐ F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____
E-mail:_____
Address:_____
City: _____ **State:**_____ **Zip:**_____
Home#: _____ **Cell#:** _____ **Work#:**_____
Pharmacy: _____ **Phone:** _____
Employer: _____ **Phone:** _____
Address: _____
Race: _____ □ **prefer not to answer** □ **do not know**
(White, American Indian, Asian, Black or *African, Native Hawaiian, Hispanic, etc.)*

Preferred Language: _____ □ **prefer not to answer**

Primary Insurance: _____ Are you the insured? ☐Ye s ☐No
Insured Information

Subscriber Name:_____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐other

Phone#:_____ Sex: ☐ Male ☐ Female DOB: __/__/__

Address: _____

Policy ID: _____ Group ID: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No
Insured Information

Subscriber Name:_____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐other

Phone#:_____ Sex: ☐ Male ☐ Female DOB: __/__/__

Address: _____

Policy ID: _____ Group ID: _____

How did you find out about our practice? ☐ Provider ☐Internet ☐Telephone book ☐Family member ☐ Friend ☐Other: _____

What is the reason for your visit today?_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? _____/10

The pain quality is: ☐ burning ☐ constant ☐ dull ☐ sharp ☐ shooting ☐ throbbing ☐ tingling ☐ other:_____

PLEASE READ AND SIGN
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the provider and/or medical staff of any and all updates to the information listed above.

_____(Patient Signature)

History and Physical Name: _____ DOB: _____

Medical History: ☐ Alcoholism ☐ Blood disorders ☐ Circulation problems
☐ Liver disease ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Musculoskeletal ☐ Breathing issues
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Heart disease ☐ Asthma
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Mental illness ☐ Kidney disease
☐ Neuropathy (*specify*)_____ ☐Thyroid disease (*specify*)_____ ☐ Diabetes (type I, type 2)
☐ Arthritis (*specify*)_____ ☐ Other (*specify*) _____ ☐ Skin disorders (*specify)*

Are you pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Surgical History

Have you ever had any surgical procedures? ☐ Yes ☐ No
If yes, please describe: _____

Social History

Do you smoke? ☐Yes ☐ No If yes how many packs per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 For how long?
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse ☐Yes, I have a current substance abuse problem. Please specify:_____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation?_____Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ Yes, I do the following regular exercise: _____
☐ No, I do not exercise regularly

Family History

Is there any family history *(blood relative)* of: *(Please indicate family member)*

☐ Alzheimer's _____ ☐ Depression _____
☐ Arthritis _____ ☐ Diabetes _____
☐ Bleeding disorders _____ ☐ Emphysema _____
☐ Blood clot _____ ☐ Heart disease _____
☐ Cancer _____ ☐ High Blood Pressure_____
☐ Cataracts _____ ☐ Neurological _____
☐ Circulation problems _____ ☐ Strokes _____
☐ Other (specify): _____

Review of Systems *(Please check the box if you currently have any of these symptoms)*

Cardiovascular	☐leg pain when walking	☐fever	☐chest pain/pressure	☐leg swelling	☐cold hands/feet
	☐fainting	☐palpitations	☐vascular disease	☐valve problems	
Genitourinary	☐blood in urine	☐hesitancy	☐incontinence	☐increased urgency	
	☐decreased frequency	☐excessive urination	☐kidney disease	☐kidney stones	
Gastrointestinal	☐abdominal pain	☐heart burn	☐blood in stool	☐vomiting	☐ulcers
	☐diarrhea	☐trouble swallowing	☐constipation	☐increase appetite	☐decrease appetite
Integumentary	☐athletes foot	☐nail abnormalities	☐keloids	☐itchiness	☐dry, scaly skin
Hematologic	☐lower leg ulcers	☐sickle cell disease	☐anemia	☐blood thinners	☐clotting disorders
Neurological	☐tingling	☐weakness	☐seizures	☐numbness	☐headaches
	☐tremors	☐paralysis			
Musculoskeletal	☐back pain	☐joint swelling	☐muscle weakness	☐muscle pain	☐neck pain
	☐sciatica	☐joint stiffness	☐joint pain	☐joint instability	☐arthritis
Respiratory	☐chest pain	☐wheezing	☐COPD	☐coughing	☐snoring
	☐shortness of breath	☐emphysema			

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the provider and/or medical staff of any and all updates to the information listed above.

_____(Patient Signature)

Practice: Medical Partners of Nevada

Name: _____ **Date of birth:** _____

Privacy Information Preferences

Can we leave voicemail on answering machine? ☐Yes ☐No

Will you allow internet-based delivery reminders like email? ☐Yes ☐No

Who can we leave messages with? ☐ Wife ☐Husband ☐Daughter ☐Son

☐ Other: _____

Current Medications ☐ None

☐ I take these prescriptions or over the counter medications:

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Name:_____Dose_____

Use the back of this form if more room is needed

Allergy	Reaction
☐ No Known Allergies	
☐ Penicillin	_____
☐ Shellfish	_____
☐ Sulfa	_____
☐ Tape	_____
☐ Latex	_____
☐ Betadine *(iodine)*	_____
☐ Aspirin	_____
☐ Tylenol™	_____
☐ Ibuprofen	_____
☐ Codeine	_____
☐ Other *(specify)*	_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the provider and/or medical staff of any and all updates to the information listed above.

_____(Patient Signature)

Medical Release Form

Authorization for the Release of Protected Health Information (PHI)

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

Address: _____

City: _____ State: _____ Zip code: _____

Contact Phone Number(s): _____

I hereby authorize the following entity to release all medical records below to:

MEDICAL PARTNERS OF NEVADA
4020 E Russell Rd, LV NV 89120
ATT: ADMINISTRATION
TEL:(702)780-1313 FAX (702)476-9073

Entity Possessing the PHI: _____

Address: _____

City:_____ Phone Number(s): _____

State: _____ Zip code: _____ Fax: _____

I understand that:

- I may refuse to sign this authorization and it is strictly voluntary.
- My treatment, payment, enrollment of eligibility of benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing to the provider authorized to release the PHI, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed.
- I have the right to receive a COPY of this form after I sign it.
- I will receive a photocopy only of my medical record and that the original will remain with Medical Partners of Nevada.

Signature of Patient or Patient's Representative (if applicable):_____ Date:_____

Relationship to Patient and Description of Authority to Act:_____

Autorización para divulgar Información Protegida de Salud (PHI siglas en inglés)

Nombre del paciente:_____ Fecha de nacimiento: _____
(apellido, primer nombre, segundo nombre)

Dirección _____

Ciudad: _____ Estado: _____ Código postal: _____

Teléfono de contacto(s): _____

Entidad que posee la PHI: _____

Dirección _____

Ciudad:_____ Teléfono: _____

Estado: _____ Código postal: _____ Fax: _____

Entiendo que:

- Puedo negarme a firmar esta autorización y es estrictamente voluntaria.
- La firma de esta autorización no puede condicionar mi tratamiento, el pago, la inscripción o el derecho a los beneficios.
- Puedo revocar esta autorización en cualquier momento por escrito al proveedor autorizado a divulgar la PHI, pero si lo hago, no tendré ningún efecto sobre las acciones realizadas antes de recibir la revocación.
- Si el solicitante o el receptor no es un plan de salud o un proveedor de atención médico, es posible que la información divulgada deje de estar protegida por las normas federales de privacidad y pueda ser divulgada.
- Tengo derecho a recibir una COPIA de este formulario después de firmarlo.
- Recibiré sólo una fotocopia de mi expediente médico y que el original permanecerá en Medical Partners of Nevada.

Firma del paciente o su representante:_____ Fecha: _____

Relación con el paciente y descripción de la autoridad para actuar:_____

Designation of Personal Representative

As required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form, you are informing us of your wish to designate the named person(s) as your "personal representative." You may revoke this designation at any time by signing and dating the revocation section of your copy of this form and returning it to this office.

DESIGNATION SECTION:

I,_____Date of Birth_____(print name and date of birth) hereby appoint the following person(s) to act as my personal representative(s) with respect to decisions involvingthe use and/or disclosure of health information that pertains to me.

PRINT Name of Personal Representative{s)/Phone number	**PRINT Relationship of each to Patient**

The Authority of this person when serving as my "personal representative" is restricted to the following functions:Description:

☐ This person is to be afforded all of the privileges that would be afforded to me with respect to my health information.

☐ This person is restricted to the following information about my health care:

_____

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this formand returning it to:

MEDICAL PARTNERS OF NEVADA
4020 E RUSSELL RD
LAS VEGAS NEVADA 89120
ATT: ADMINISTRATION

I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this designation.

_____ _____
Signature Date

REVOCATION SECTION:

I hereby revoke the designation of_____as my personal representative.

_____ _____
Signature Date

Medical Partners of Nevada
4020 E RUSSELL RD
LAS VEGAS NEVADA 89120

Responsibility for Payment/Receipt of HIPAA Notice/Patient Communication

I understand that I am fully responsible for all fees due to Medical Partners of Nevada or any associated medical provider (collectively referred to as the "Clinic") as a result of services I have received and that all fees are due and payable at the time of service unless Clinic agrees to accept assignment of my Medicare, Medicaid or other insurance benefits.

If I have insurance coverage other than Medicare:

I understand that assigning benefits to the Clinic and the filing of an insurance claim on my behalf is a courtesy to me and this is not absolving me of my responsibility to pay for services if the insurance company fails to pay for these services or if deductibles and/or co-pays are due. I understand that my insurance policy may not cover the full cost of services, or may consider it an uncovered service or medically unnecessary, or I may not have coverage benefits for these services. I therefore agree to be responsible for those charges incurred, as well as for my co-pay and/or any deductible that has not been met.

I further understand that any verification of my insurance benefits by the Clinic is not a guarantee of payment by my insurance company. If my insurance company does not pay for the services I have received, or fails to pay within 60 days of service, I understand that the Clinic will bill me for these services and I agree to pay any amounts due within 10 days of receipt of a bill for these services. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by my insurance company and the actual charge for that service.

If I am covered under Medicare or a Medicare Advantage health plan:

I understand that I will be responsible for my co-pay and/or any deductible that has not been met either through my Medicare coverage or any supplemental policy that I may also have. In addition, if a claim is filed on my behalf as an unassigned claim, then I will also be responsible for the difference between the amount paid by Medicare and the actual charge for that service.

I further understand that I will be notified in advance by an Advanced Beneficiary Notice of Noncoverage if Medicare likely will not pay for items or services. I will then have the right to make an informed choice whether or not to receive the items or services. If I choose to receive the items or services, I am aware that I will be responsible for paying for such items or services.

I request that payment of authorized Medicare, Medicaid or other insurance benefits be made on my behalf to the Clinic for any services furnished to me subject to any regulations pertaining to their assignment of benefits. I authorize any holder of my medical information to release to the Centers for Medicare & Medicaid Services, Social Security Administration and its agents, intermediaries or carriers, or to any other third-party sources or insurance companies and its agents any information or documentation needed to determine these benefits or the benefits payable for related services. A copy of this authorization may be used in place of an original and this authorization shall remain in force until revoked by me in writing.

I certify that the insurance information given by me is current and accurate to the best of my knowledge and I understand and agree to abide by the terms outlined above.

I **further acknowledge that I have received a copy of the Clinic's Notice of Privacy Practices.**

I **agree to receive appointment and treatment reminders via text and voicemail:** YES ☐ NO ☐

Patient Name (Please Print)	Date	Patient or Responsible Party Signature

Relationship to Patient	Reason Patient Cannot Sign (if applicable)

4020 E RUSSELL RD
LAS VEGAS NEVADA 89120

Consent for Treatment

I, _____, am voluntarily seeking healthcare
(Patient's name)

and hereby consent to medical treatment, procedures, laboratory tests and other health care services. I understand that I have the right to refuse specific treatments or procedures. However, by signing below, I agree in general, to permit laboratory and diagnostic tests, routine medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency procedures as necessary, and hospital services performed at the request of the attending provider or other providers assisting in my care.

Provider does not participate in Worker's Compensation and Car Accident Claims; therefore provider notes cannot be used in any legal case.

The consent given shall be valid and binding and provider(s) can rely on this authorization and accept any consent given by the patient until such time as provider receives written notice that the authorization is revoked.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Signature of Patient or Legal Representative Relationship

_____

Date

Medical
Partners of
Nevada
4020 E RUSSELL RD
LAS VEGAS NEVADA 89120
(702)780-1313

MEDICATION REFILL POLICY

1. Requests for medication refills will only be considered during regular office hours in clinic; Monday- Thursday 9:00 a.m. to 5:00 p.m. No refills will be given after hours, weekends, or holidays. All refill requests must be received by Thursday to be refilled for the weekend.

2. Requests for medication refills should be called to your pharmacy who will, in turn, call our office. Please allow 48 hours for this procedure. No refills of medications will be given if you have not been seen for 3 months. Your refill will need to be reviewed by your provider and might not be refilled until you have been reevaluated. It is your responsibility to make a follow-up appointment with your provider. This will be strictly enforced.

3. If you call for medication or refills outside regular office hours, you will be instructed to go to the emergency room. There, you will be evaluated by an emergency room physician who will decide whether or not to refill your medication. Emergency Department Policy regarding medication refills is typically very strict and there is no guarantee that you will get your refill. If the Emergency Department is busy, you may be required to wait a long m period of time to be seen.

4. Telephone requests for prescription renewals are accepted only during regular business hours. In some instances, there is a 48 to 72 hour waiting period before prescriptions will be refilled, so call your refills accordingly. We are very cautious about refilling your medications too early, so follow your instructions carefully.

Print Patient Name	Date of Birth
Patient Signature	Date

In accordance with the Health Insurance Portability and Accountability Actof 1996, as of April 14, 2003 all health care providers are required to provide their patients with a 'Notice of Privacy Practice' statement.

MEDICAL PARTNERS OF NEVADA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Medical Partners of Nevada is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Medical Partners of Nevada."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Medical Partners of Nevada to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Medical Partners of Nevada for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers'Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking,or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that hasbeen approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner andgovernment benefits purposes.

Marketing.
We may contact you for this purpose, as described below: (example)

> *"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*
>
> *"It is our practice to participate in events to raise awareness. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in these events. We will provide you with information about the type of activity, the dates and times."*

Change of Ownership.
In the event that Medical Partners of Nevada is sold or merged with another organization, yourhealth information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Medical Partners of Nevada is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative

method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.
- You have a right to request that Medical Partners of Nevada amend your protected health information. Please be advised, however, that Medical Partners of Nevada is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Medical Partners of Nevada.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Medical Partners of Nevada reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Medical Partners of Nevada is required by law to comply with this Notice.

Medical Partners of Nevada is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact the Office Manager by calling this office at 702-780-1313. If the Office Manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how Medical Partners of Nevada has handled your health information should be directed to Carlos Reyes by calling this office at 702-780-1313. If Carlos Reyes is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, youmay submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue,
S.W.Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Medical Partners of Nevada with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)_____

Patient's Signature_____ Date_____

Authorized Facility Signature_____ Date_____

4020 E RUSSELL RD
LAS VEGAS NEVADA 89120
(702)780-1313

Chronic Care Management Patient Agreement

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow MEDICAL PARTNERS OF NEVADA to provide chronic care management services to you. CCM services are only available to patients with two or more chronic conditions.

Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, andthat increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of CCM Services include:

- 24/7 access to a care provider to help with your chronic healthcare needs a comprehensive plan of care for health needs, available on paper or electronically.
- Coordination with both home and community-based service providers
- Transition management among health care providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Medication oversight and management
- Use of a certified electronic health record (EHR) as mandated by Medicare.
- Should you desire to receive CCM services through your provider, he/she agrees to only bill Medicare for CCM services once per 30-day billing cycle. Furthermore, your provider agrees only tobill Medicare for CCM services if you have more than one chronic condition.

Beneficiary Acknowledgment and Agreement

By signing this agreement, you agree to the following terms:

You consent to your provider providing CCM services to you. You certify that your provider has fully explained the scope of CCM services to you. You acknowledge that only one practitioner can furnish andbe paid for CCM services during a calendar month. You authorize electronic communication of your medical information between treating providers as part of your care. You understand that CCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the CCM services.

You understand that you have the right to terminate CCM services at any time by revoking this agreement effective at the end of the then-current month. You may revoke this agreement verbally by notifying by telephone at (702) 780-1313, or by mailing your written revocation to 4020 E Russell Rd, Las Vegas Nevada 89120. Your provider will then be given your written confirmation, including the effective date of revocation.

Beneficiary/Responsible Party Signature:_____

Print Name:_____ Date:_____

Medical
Partners of
Nevada
4020 E RUSSELL RD
LAS VEGAS NEVADA 89120
(702)780-1313

NO SHOW POLICY AND AGREEMENT

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than a 24-hour notice. Patients who do not show up nor provide more than a 24-hour notice are considered a NO SHOW. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice. A FEE OF $50.00 WILL BE BILLED FOR ALL NO SHOW APPOINTMENTS.

BY SIGNING BELOW, I ACKNOWLEDGE AND AGREE TO THE NO SHOW POLICY FEE.

_____
Date

_____ _____
Patient Name Signature