BRIDGEWAY
HEALTH SERVICES

Notice of Privacy Practice and Office Policy

I have been given the opportunity to read and receive a copy of at my request, the Notice of Privacy Practices, and office policy on no shows and cancellation fees.

The medical history is complete and accurate to the best of my knowledge. I authorize the release of any medical information necessary and needed to receive payment and authorize payment of medical benefits to the Provider from my insurance carrier. Bridgeway Health Services has advised me that certain services provided to me by this office may not be reimbursed by my insurance, and will be my sole responsibility. This includes no shows, same day cancellations, and any charge that my insurance does not cover. At my request, a copy of this disclosure will be provided to me and explained by the Business Manager.

I request payment of authorized insurance benefits for any and all services furnished to me, be made payable to Bridgeway Health Services on my behalf. I consent to and authorize Bridgeway Health Services to provide pertinent information to bill my insurance benefits and any holder of medical information concerning me, to release information needed to determine these benefits payable for related services.

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Patient Signature: Date:

(Parent / Guardian if patient is a minor child)