ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ________________________________ DOB: ____________________

Please initial each line below:

_________ I have reviewed the "Summary Notice of Privacy Practices for Protected Health Information".

_________ I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

_________ I authorize my physician to release patient information as dictated by HIPPA policy, including the community exchange, public health reporting, and as dictated by court order.

_________ I agree to retrieval of my medication history including but not limited to pharmacy information retrieval.

_________ I agree to have my medical records made available to other medical professionals for patient referrals/ consultations or upon transition of patient care.

_________ I acknowledge that it is the policy of Beyond Aesthetic Medicine to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

_________ I understand that I am financially responsible for all charges. My insurance company will not be billed.

_________ I understand that I am responsible for arriving on time to all of my scheduled appointments, or the appointment will be forfeited. Appointment reminders from Beyond Aesthetics are a courtesy.

_________ I understand that children are not allowed in the office unless being treated.

____ ________________________
Signature of Patient/Guardian Date

____ ________________________
Witness (Office Staff) Date

ACCEPTANCE OF OFFICE TREATMENT POLICIES

All services must be completed within 365 days from first treatment or remaining services will be forfeited.

Refunds: *Credit for service or product is deducted from your account at the 'Standard Price' per visit until the credit balance is zero. There is no refund for service or product that has been delivered, or for undelivered service or product if there is no credit balance.*

Patient/Guardian Signature X____ **Date** _______________

Consultant Signature ____ Date ____________________

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