I agree to be responsible for payment of all services rendered on my behalf and of my dependents. Should I decide to submit receipts from this office to my insurance carrier for reimbursement, I understand that they may pay less than the actual bill for services or nothing at all.

Explanation of Fees:

New Patient Visit:	$140.00
45-minute visit:	$100.00
30-minute visit:	$ 80.00
15-minute visit:	$ 50.00

Cash, Check, Credit Cards, HAS and FSA Cards are accepted as payment.

Patient Signature (parent if minor): _____Date:_____

Privacy Notice Acknowledgement

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), we are required to supply you with a copy of our privacy policies procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature (parent if minor): _____Date:_____