

APPOINTMENT AGREEMENT

We reserve time in our schedule especially for your child. In consideration of others, we kindly request at least 2 business days' notice prior to cancellation or rescheduling any appointments.

We do understand that there are circumstances that may prevent you from keeping your child's appointment, however, by providing us as much notice as possible, we may be able to contact another family who would like that appointment time. Canceling with less than 2 business days notice does not allow us enough time to schedule another patient in need of treatment.

You will receive two letters for missed appointments without proper notice given. After the second letter, you will be placed on a "same day appointment" list. On a day that you feel it is convenient to bring your child in, call our office and we will put them in our schedule if time allows.

Patients that are running late are asked to call the office as soon as possible to check with the front office team if they will still be able to keep their appointment. Cancellations left on our voicemail are not accepted and will not be considered canceled. Please call during regular business hours and speak with a team member if you need to make a change.

In consideration of other patients, your child's appointment may be reschedule if you are more than 15 minutes late for your scheduled appointment time.

School holidays, as well as before and after school hours are our most popular appointment times. Appointments canceled with less than 2 business days' notice that are scheduled on a school holiday, before or after school time will not be rescheduled on another school holiday, before or after school appointment time.

We greatly appreciate your cooperation in helping us provide you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you.

Patient's Name: _____

Parent/Guardian: _____

Date: _____

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

First Name Only Proper Surname Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- | | |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Email Confirmation |
| <input type="checkbox"/> Text Message to my Cell Phone | <input type="checkbox"/> Work Phone Confirmation |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Any of the Above |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS** or **NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- | | |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> Any of the Above |
| <input type="checkbox"/> Text Message | <input type="checkbox"/> None of the Above (opt out) |
| <input type="checkbox"/> Email | |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

Please *print* name of Patient

Please *sign* Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment
 I could not communicate with the patient
 The patient refused to sign
 The patient was unable to sign because
 Other (please describe) _____

Signature of Privacy Officer _____