FAMILY
CARE CENTER

"Exercise is Medicine"

HIPAA & FINANCIAL POLICY

Form expires one year after date of signature

Patient Name:____ **DOB:** ________________

- I acknowledge that I have received or have been offered the notice of privacy practices from Family Care Center.
- I acknowledge that I have read, understand and received a copy of the financial policy. **I further understand that part of the financial policy includes policies relating to unpaid copayment, "no showed" and "late cancel" appointments. I understand that Family Care Center expects full payment within 30 days from me on patient balances.** If I am self-pay (no insurance), I understand that I am expected to pay my charges in full on the date that I am seen.
- I give permission to Family Care Center employees to release information regarding my medical, demographics, and billing information to the following entities:

Spouse: ___________________________ **Other**:_______________________________________

- I authorize the providers at Family Care Center to provide medical treatment to me OR my minor child. This authorization is valid for one year from date of signing.

X____ **Date**__________________

Signature of Patient (Parent/Guardian)

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