601 E. Chicago Rd.
Coldwater, MI 49036
517-278-7246

ACKNOWLEDGEMENT FORM

I____was offered/have received a copy of this office's ***Notice of Privacy Practices***. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care options such as quality assessments and accreditation.

Preferred method of contact: Home / work / text / email: ____

____ ____________________
(Signature of Individual or Legal Guardian/Representative) (Date)

Other person(s) allowed access to your health information:

Name	Relationship
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Insurance Assignment and Financial Policy

A policy of this office is to extend to our patients the courtesy of assigning your insurance benefits to us. This assignment begins with receiving a copy of your insurance card.

1. We will do our best to verify your insurance coverage.
2. All deductibles, co-pays, or other out-of-pocket expenses are expected prior to insurance submittal.
3. Your out-of-pocket expense balance may not exceed $100 or services may be postponed.
4. Since this office does not own the insurance policy, we cannot promise that your insurance company will pay for the usual and customary charges of this office, nor will this office enter a dispute with an insurance company over reimbursement. If we experience difficulty collecting from your insurance company, we will ask that you act on your own behalf with your insurance company.

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and me, not between my insurance company and this office. If there is a deductible, co-pay, or other out-of-pocket expense - I agree to pay my portion as services are rendered, unless other arrangements have been made.

I understand that I am ultimately responsible for payment in full at this office. In the event default in payment of any amount due, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, I agree to pay an additional charge equal to the cost of collection including collection agency and attorney fees and court costs incurred.

Primary Insurance ____

Employer ____

Name on Card ____

DOB ________________________ Patient Relationship to Cardholder: self spouse child

Secondary Insurance ____

Employer ____

Name on Card ____

DOB ________________________ Patient Relationship to Cardholder: self spouse child

____ ______________________

Patient Signature / Parent or Legal Guardian Date

601 E. Chicago Rd. Coldwater, MI 49036 Ph. 517-278-7246 Fax: 517-279-2858