Hilliard Family PODIATRY, LLC.

Jennifer Trinidad, D.P.M. Adam Thomas, D.P.M.

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

Patient Name:_____ Date of Registration:_____

By signing this form, you acknowledge that Hilliard Family PODIATRY, LLC has provided you access to a copy of its HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form on your first date of service with us. If your first date of service with us was due to an emergency, we must try to provide you access to this notice and have you sign this form as soon as we can after the emergency.

Please specify by checking the appropriate answer below if we may leave health related information (e.g., lab/radiology results, billing issues or other doctor patient communications) with/on:

Home Answering Machine: ___Yes ___No Work Voicemail: ___Yes ___No Personal/Work Email: ___Yes ___No

Relative or Other Person Living with You _____Yes _____No Names: _____

_____

Please note that if the above section is not completed, we will assume that we have your approval to contact you using any one of these methods.

[ ] The Practice has provided me with a copy of its Privacy Notice. I acknowledge that I have read, understand and agree to the above.

[ ] I have read the Privacy Notice and **DO NOT AGREE** to its provisions.

_____ _____

Patient's/Guardian Signature Date

FINANCIAL POLICY

PATIENT FINANCIAL RESPONSIBILITY FOR NO INSURNACE: If no insurance is to be filed by us, full payment is expected at the time of service.

CO-PAYMENTS: Are due at the time of service. We accept cash, checks and credit cards.

MINORS/DEPENDENTS: Only a parent, custodial parent in a divorce situation or guardian are able to authorize treatment. The parent, custodial parent or guardian is responsible for the full fee for services. A copy of the custodial or guardianship agreement is requested for our records if applicable.

NSF FEES: A fee of at least $25 but no less than the amount charged by the bank will be added to the patient's account per submission in cases of returned checks for non-sufficient funds (NSF).

PAST DUE ACCOUNTS: Outstanding balances after insurance payment will be invoiced to the responsible party on a statement. Payment is due upon receipt of the statement. Prolonged delinquency in payment may result in preparation of account for small claims court, collection agency and/or credit bureau reporting with possible discharge from the practice. In the event an account is turned over for collection the person financially responsible for the account will be responsible for all collection costs including interest, collection fees, and reasonable attorney fees and court costs.

MISSED APPOINTMENTS: We request the courtesy of a 24-hour notice of cancellation. After missed appointments, $20 maybe charged your account. We also reserve the right not to schedule you with our office any further, or you may be discharged from the practice entirely.

FINANCIAL AGREEMENT: By signing this form, I, the patient, or the patient's representative, acknowledges that I have read, understood and received a copy of the HILLIARD FAMILY PODIATRY, LLC'S financial policy. I understand and agree, regardless of my insurance status, that I am responsible for the balance of my account.

_____ _____ _____

Patient's/Guardian Signature Printed Name Signature Date