DR. MAYS & SUE GRIFFIN, ARNP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please print your name, write your social security number and date this acknowledgement form. Return this acknowledgment form to a member of the front desk staff or the address listed in the Notice of Privacy Practices.

Printed Name: _____

S S # : _____

I have read a copy of the Provided Notice of Privacy Practices _____(initial)

Further, I hereby authorize and give my consent to Dr. Stricker Mays to leave messages on my answering machine/voice mail system for the following:

□ Appointment Reminders □ Prescription Refills

□ Medical information (including returned phone calls.) □ Test results

Further, I hereby authorize and give my consent to Dr. Stricker Mays to communicate any of my Protected Health information to the following persons:

NAME	RELATIONSHIP

OFFICE POLICIES, EFECTIVE 10/01/09

INSURANCE: It is your responsibility to provide our office with your current insurance information. Please review your policy to ensure that Dr. Mays is a participating provider. If your insurance requires an authorization or specific lab for your visit, it is the patient's responsibility to provide that to our office prior to your scheduled appointment. Not all procedures are covered at 100% by your insurance. All balances will be the patient's responsibility. Specimens collected on day of service, will be sent to outside laboratory for interpretation and will be billed from that facility.

MISSED APPOINTMENTS: We understand there will be times when a scheduled appointment cannot be kept. If you need to cancel or reschedule your appointment, we request that you notify our office 24 hours in advance, to allow us to fill that time with another patient appointment. If you are unable to follow this policy, a **missed appointment fee of $25.00** will be added to your account. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment. Multiple missed appointments may result in dismissal from our practice.

FORMS: There will be a $25.00 charge for disability, FMLA or any other insurance paperwork.

PAYMENTS: Co-pays as well as all existing balances are kindly expected at the time of your visit. A fee of **$35.00** will be charged for any returned checks.

By your signature below, you are agreeing that you have been informed of the above policies.

Signature: _____ Date : _____