Harford Lower Extremity Specialists
437 South Main Street, Bel Air, Maryland 21014
Phone: 410-836-0131 Fax: 410-836-8594
www.hlsfootcare.com

PF-2000 Acknowledgment of Receipt of Notice of Privacy Practices

Harford Lower Extremity Specialists reserves the right to modify the privacy practices outlined in the notice.

- I have been given the option to receive or downloaded a copy of the Notice of Privacy Practices for **Harford Lower Extremity Specialists** from the Practice website (http://hlsfootcare.com/new_patient.html).

- Please **do not** use my information for fund raising purposes

- I understand that honest and complete answers to each question asked in this medical history

- Questionnaire is important to the provision of my medical care. I have answered them to the best of my ability.
  I assume all risks which occur as a result of my failure or refusal to disclose all medical information. I understand that if I am uncertain about any questions, I should ask the doctor or a member of the office staff for assistance.

- I have received a copy of the Financial Policy. I further understand that my signature signifies that I accept the terms as set forth in this program.

- Please identify anyone to whom you grant personal data and information about your care to be released to: (Spouse, parent, sibling, power of attorney, etc.)

Name: _____ Relationship: _____

Benefits to the Physician's office:
I hereby authorize payments directly to the physician of the medical/surgical benefits.

I also understand I am responsible for any portion of my bill not covered by my insurance; Patient balances are due in 30 days. Interest will accrue at 1.5% on accounts over 60 days with no payment arrangements. Delinquent accounts are sent to collections and have adverse effects on credit history. Insufficient fund checks will be recovered by Re$ubmitit. **THERE ARE NO REFUNDS ON CUSTOM or OVER THE COUNTER PRODUCTS. CREDIT CARD REFUNDS MUST BE IN PERSON.**
I hereby authorize release of information for insurance claim purposes.

MISSED APPOINTMENTS HURT YOU, THE DOCTOR AND SOMEONE IN NEED OF CARE.
MISSED APPOINTMENTS WITHOUT 24 HOUR NOTIFICATION WILL BE ASSESSED:
NEW PATIENTS $75.00, CURRENT PATIENTS $50.00.

*** you must understand that text authorization may incur a landline fee to your phone***

I understand all of the above and hereby state that the information is correct to the best of my knowledge.

Signature	Date
Witness	Date