

JACKSONVILLE OTOLARYNGOLOGY & FACIAL PLASTIC SURGERY, P.A.

PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

PHONE NUMBER: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE FOR JACKSONVILLE OTOLARYNGOLOGY AND FACIAL PLASTIC SURGERY, P.A.

We are required by law to provide you with a copy of our Notice of Privacy Practice. To ensure that our records are accurate, please sign this form and return it to our receptionist. To acknowledge that you have been provided with a copy of our notice.

OUR FINANCIAL POLICY

REGARDING INSURANCE

Regarding insurance plans where we are a participating provider: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All copays and deductibles are due prior to treatment, along with a valid referral from your primary care provider, if your insurance plan requires it. Please note that if you require treatment that is not deemed medically necessary or is not a covered service with your insurance carrier, you will be responsible for payment in full prior to that treatment.

Certain procedures such as the use of a microscope or endoscope are necessary for the evaluation or management of your condition. These procedures may or may not be covered under your office visit or copay. Some insurance companies require that these charges apply toward your deductible. You will be responsible for these additional charges.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of **\$30.00**. This is not covered by insurance. We call 12 hours in advance, at which time you may cancel your appointment without being charged. Please help us serve you better by keeping scheduled appointments.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

DATE