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DISCLAIMER & RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

RE: SCHEDULING OF ANY OUTPATIENT TEST (Laboratory Test, Ultrasound, Hysterosalpingogram, Sonohysterogram, Mammogram, MRI, CT Scan, Bone Density Scan, Etc.) **OUTPATIENT SURGERIES OR HOSPITAL ADMISSIONS.**

With all the changes in healthcare today, it is very difficult to keep abreast of which facilities are "PREFERRED PROVIDERS" for each insurance carrier. Every effort is given to scheduling your procedure at a facility that is a contracted provider for your insurance.

However, ultimately the responsibility for guaranteeing that you are being scheduled with a "PREFERRED PROVIDER" falls on **YOU, THE PATIENT.** We advise you to double check with your insurance company, either via your provider book or by calling the insurance company directly-as well as to check with the facility itself to ensure that we have scheduled you with a "PREFERRED PROVIDER." Incorrect facilities (Non-preferred/non-participating/out-of-network) can lead to reductions in your benefits and increased cost to you.

If you find that you are scheduled at a non-participating facility, please contact this office immediately. This must be done prior to your service.

The Doctor, Nurse Practitioners, and the office staff ***WILL NOT*** be held responsible for any disallowed charges due to facility not being a "PREFERRED PROVIDER."

I choose to:

______Decline a copy of the written Privacy Policy.
(Initial)

______Receive a copy of the written Privacy Policy.
(Initial)

Authorize the following individual access to my medical record.

______________________________ ______________________________
Name Relationship

I HAVE READ THE ABOVE DISCLAIMERS AND FULLY UNDERSTAND THEM.

Patient Signature:______________________________ Date:____________________