Patient Acknowledgement of Privacy Practices & Financial Policy

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, however if we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice Notebook that is posted in our Clinic Lobby
- The practice reserves the right to change the Notice of Privacy Practices
- Dr. Sheila L. Scott AP reserves the right to leave confidential messages (i.e., appointment reminders) on you telephone answering machine or voice mail. Please print the telephone number where you want to receive calls about your appointments if other than your home phone number: ______________ (cell) or (work) ____________
- The patient may revoke this consent in writing at any time with the Privacy Officer (Clinic Manager) and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent
- All mail correspondence will be sent to you, the patient, in a sealed envelope

This Consent was signed by: ___________________________ (Signature-patient or representative)

Relationship to patient (if other than patient): __________ Witness: ____________________

Date: _______________

Statement of Financial Policy & Fee Schedule

- Please see Fee Schedule-Dr. Sheila L. Scott AP MSOM for all Fees
- There is a $ 25 fee for all returned checks
- 24 hours' notice prior to canceling an appointment is required to avoid a $30 cancellation fee
- We accept all major credit and debit cards, as well as Health Savings Accounts

I have read and understand the clinic fee schedule & Financial Policy of Dr. Sheila L. Scott AP MSOM.

Patient Signature: ____________________________