WASHINGTON SPORTS & SPINE

FORMO ENTERPRISES, INC

FORMO ENTERPRISES, INC. has provided me with a privacy notice brochure that makes me fully aware of my rights concerning HIPPA (Health Information Privacy Act of America). My signature below confirms my review of this information and its availability at WA SPORTS & SPINE.

Signature:____ Date:____________

OUR OFFICE POLICY IS AS FOLLOWS:

As a courtesy to our patients, we are happy to verify your insurance benefits and bill your insurance carrier. However, their verification is not a guarantee of payment. At the time of receipt of our billing, your insurance carrier will make a final determination of payment. If payment is denied by them, it is your responsibility to pay the charges in full.

If no insurance, all office visits, exams, and supplies must be paid at the time of visits. Past due balances are subject to a $10.00 per month billing fee and any reasonable collections, attorney fees and costs are due by you.

Cancellation policy: Failure to call 24 hours prior to an appointment to cancel will result in a charge of a $35.00 no show fee.

I authorize the staff to perform any necessary service needed during diagnosis and treatment. I also authorize the provider and staff to release any information required to process my insurance claims. <u>I understand that I am responsible for payment of my account and that my insurance coverage is a contract between me and my insurance.</u>

Signature:____ Date:____________