Patient Name: _____
(PLEASE PRINT)

Acknowledgement

Receipt of Privacy Practices

I have received a Notice of Dr. Schroeder's Privacy Practices (version 05/2014) and have had a chance to review it and ask any questions.

(Please sign here to acknowledge receipt):

_____ _____
(SIGNATURE) (DATE)

Receipt of Office Policies

I have received a copy of Dr. Schroeder's office policies (version 05/2014) and have had a chance to review it and ask any questions.

Specifically, I acknowledge an understanding of the following:

(Please initial):

_____Payment is due at the time of service.

_____Dr. Schroeder makes no guarantee that my insurance company will reimburse me.

_____Missed Appointments (and/or failure to provide 24-hours notice of cancellation) will result in a $125 missed appointment charge.

(Please sign here to acknowledge receipt):

_____ _____
(SIGNATURE) (DATE)