Carlsbad Village Family Practice Medical Associates, Inc.

GENERAL OFFICE POLICIES

Notice of Privacy Practices
A notice of Privacy Practices is available for your review. If you would like to have/read a copy of the Notices of Uses and Disclosure of Protected Medical Information, please ask the front desk for your copy. My signature below indicates that I have been notified about the Privacy Policies(Notices of Uses and Disclosure of Protected Medical Information).
Patient or Responsible Party
Signature: _____ Date _____/_____/_____

Financial Policy
I hereby authorize Carlsbad Village Family Practice Medical Associates, Inc. to apply for benefits on my behalf for the services I have received and release any pertinent medical information, to my Insurance Carrier listed above. I authorize payment of medical benefits directly to Carlsbad Village Family Practice Medical Associates, Inc. I understand that my insurance carrier may not cover all services provided and I may be responsible for any services that are non-covered. I certify that the insurance information that I have provided is accurate and understand that if it is not up to date that I will be financially responsible for the services provided. I understand that I will be responsible for any fees relating to my account being sent to an outside collection agency or attorney. All cosmetic services and/or product purchases are payable at the time of service.

Cancellation Policy/"No Show" Policy
Carlsbad Village Family Practice Medical Associates, Inc requires a 24 hour notice when cancelling any appointment. I understand that I may be liable for a charge of $35.00 if I fail to give 24 hours notice to cancel or I "no show" for an appointment.

Return Check Policy
Carlsbad Village Family Practice Medical Associates, Inc charges $35.00 for all returned checks.

I have read and understand the above policies.
Signature_____ Date _____/_____/_____