MIDDLE COUNTRY ENDOCRINOLOGY, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____, acknowledge that I have read and understand, Middle Country Endocinology's Notice of Privacy Practices. This notice describes how Middle Country Endocrinology may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient, or Personal Representative **Date**

ACCESS TO MEDICAL RECORDS

The person/persons listed below may have access to my medical records.

_____ _____

Name **Relation to Patient**

_____ _____

Name **Relation to Patient**

I give permission for Middle Country Endocrinology to leave a message on my answering machine or voice mail regarding my medical results.

_____ _____

Signature **Date**

_____ _____

Print Name **Phone Number**

MIDDLE COUNTRY ENDOCRINOLOGY OFFICE POLICIES

- **24 HOUR NOTICE IS REQUIRED WHEN CANCELLING APPOINTMENTS. IF WE DO NOT RECEIVE PROPER NOTICE, WE RESERVE THE RIGHT TO CHARGE THE PATIENT A $25.00 FEE FOR LOST TIME.**
- **WE REQUIRE YOU TO ARRIVE ON TIME FOR YOUR APPOINTMENT, BUT WE UNDERSTAND THAT SOME CIRCUMSTANCES MAY MAKE THIS IMPOSSIBLE, THEREFORE WE UPHOLD A STRICT 15 MINUTE LATE POLICY. WE RESERVE THE RIGHT TO RESCHEDULE YOUR APPOINTMENT IF YOU ARE MORE THAN 15 MINUTES LATE.**
- **IF A REFERRAL IS REQUIRED BY YOUR INSURANCE COMPANY, IT IS YOUR RESPONSIBILITY TO OBTAIN ONE FROM YOUR PRIMARY CARE DOCTOR. IF YOU DO NOT HAVE A REFERRAL YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.**
- **ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE, WE ACCEPT CASH,CHECKS AND CREDIT CARDS FOR YOUR CONVENIENCE.**

BY SIGNING BELOW, I AGREE TO AND UNDERSTAND THE ABOVE STATED OFFICE POLICIES OF MIDDLE COUNTRY ENDOCRINOLOGY.

_____ _____

SIGNATURE **DATE**