HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

By signing below, I hereby acknowledge the receipt of FORTÉ SPORTS MEDICINE AND ORTHOPEDICS Notice of Privacy Practices.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

FOR OFFICE USE ONLY:

Good Faith Effort was used to obtain acknowledgement, but despite this effort, the

☐ Patient Refused

☐ Patient Unable Due To: _____

Staff member's signature: _____

Date: _____

FORTÉ SPORTS MEDICINE AND ORTHOPEDICS NO SHOW/CANCELLATION POLICY

Thank you for trusting your medical needs to Forté Sports Medicine and Orthopedics. When you schedule an appointment, we set aside time to provide you with the highest quality of care. Should you need to reschedule or cancel an appointment, contact our office no later than 24 hours prior to your scheduled appointment. This policy is in effect from January 1st to December 31st each calendar year. See our No Show/Cancellation Policy below:

1. Any established patient who fails to show or cancel an appointment 24 hours prior to a scheduled appointment will be considered a no show. There is no charge for the 1st occurrence.
2. Any established patient who fails to show or cancel an appointment without a 24-hour notice for the second time will be considered a no show, 2nd occurrence. You will be charged $25.00. This is billed directly to you, not to insurance.
3. Any established patient who fails to show or cancel an appointment without a 24-hour notice for the 3rd time will be considered a no show, 3rd occurrence. You will be charged $50.00. This will be billed directly to you, not to insurance. You will be blocked from scheduling any future appointments until both no show fees have been paid.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Front Office Manager at 317-208-1568. The Front Office Manager may be able to waive the No Show fee.

I acknowledge that I have been made aware of the No Show Policy.

_____ _____

Signature (Patient or Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

*Refusal to sign the acknowledgement of the policy does not exempt you from our company policy.

Patient Refused: _____ Date/Time: _____ Staff Witness: _____