VALLEY WOUND HEALING CENTER POLICY'S

Terms of Payments

Initial_____ Payments of all copays and deductibles are due at the time of service. As a service to you, our office will bill your insurance company. For your convenience, we accept cash, checks, credit cards, and debit cards. Due to the constant changes in health insurance it is your responsibility to know your health coverage.

Use of Electronics

Initial_____ Due to HIPAA and privacy laws, the use of personal electronics is prohibited all throughout the office. If a phone call is necessary, you must take your phone call outside. You will be asked to leave if the policy is not followed.

Late Arrivals and Non-Compliance

Initial_____ If you are 15 minutes past your scheduled appointment, your appointment will be rescheduled at our discretion. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. If you do not show up to your appointment or cancel your appointment without at least a **24-hour** notice, there will be a **$30 fee** charged to you. Continuous no-show appointments may result in an immediate discharge from our facility.

PRIVACY PRACTICE AGREEMENT

Initial____ **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your personal health information to carry out treatment, payment activities, and healthcare operations.

CONSENT TO PHOTOGRAPH

Initial____ I consent that photographs may be taken in connection with the services I am receiving. I understand the necessity for the photographs, and that they shall become part of my medical records.

CERTIFICATION OF ELIGIBILITY

Initial____ It is my understanding that these benefits became effective on or is effective on today's date. I am aware that if the above is not true, I be responsible for all charges related to services provided to me.

Patient/Responsible Party's Signature:_____ Date: _____