ACKNOWLEDGEMENT OR NOTICE OF PRIVACY PRACTICES

PLEASE INITIAL **X** BELOW

X _____ I have been provided with a copy of urgENT's Notice of Privacy Practices. I understand I am entitled to a copy of this document.

NO SHOW POLICY

X _____ I understand that there is a $25 NO SHOW FEE if I do not cancel my appointment within 24 hours prior to my scheduled appointment. This fee may also be applied if I arrive more than 15 minutes late to my appointment.

MEDICAID SECONDARY POLICY

X _____ I understand that I have been advised that the offices of urgENT do NOT accept Medicaid as secondary coverage. I understand that I am responsible for any co-payments or co-insurance that my primary insurance leaves as a balance due to this policy.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

AUTHORIZATION OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the following to have access to my health information:

Name:	**Relationship:**
_____	_____
_____	_____