

Please return this form to our front desk...it will be scanned into your permanent medical record.

NOTICE OF PRIVACY PRACTICES and ACKNOWLEDGEMENT OF BENEFITS

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so, or as stated in our **Notice of Privacy Practices**. You may see your record or get more information about it by contacting Dr. M. Craig Simpson.

X _____
Patient or legally authorized individual signature

X _____
Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and/or surgical benefits(insurance payments), to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Wintergreen Medical Center (WMC). A copy of this form is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize WMC to release all information necessary to secure payment from insurance companies.

X _____
Patient or legally authorized individual signature

X _____
Date

POLICY FOR MISSED APPOINTMENTS

I hereby understand that due to lost revenue caused by missed appointments, I will be charged \$30 any time that I miss an appointment or do not provide at least 6 hours advance notice of a missed appointment. This fee will be solely my responsibility, and not the responsibility of my insurance company.

X _____
Patient or legally authorized individual signature

X _____
Date

NOTICE OF INPATIENT (HOSPITAL) CARE

I understand that when I am hospitalized at PCMH, I will be admitted and cared for by a member of the PCMH Hospitalist Service, and not by Dr. Simpson or Mr. Ellis.

X _____
Patient or legally authorized individual signature

X _____
Date

NOTICE OF PEDIATRIC CARE FOR ACUTE AND/OR MINOR ILLNESSES ONLY

I understand that this office will not be providing hospitalization services to pediatric patients, and therefore, will only see that patient population for acute or minor issues, not for chronic illnesses such as asthma or epilepsy or cancer.

X _____
Patient or legally authorized individual signature

X _____
Date

X _____
Printed name if signed on behalf of the patient

X _____
Relationship (parent, legal guardian, representative)