Policies of Continuum Health Care

I hereby consent to and authorize the performance of all treatments, minor procedures performed by the provider at the clinic, venipuncture, radiology deemed advisable by the physicians &/or mid-level providers of Continuum Health Care. I hereby certify that, to the best of my knowledge, all statements contained on this form hereon are correct and true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Continuum Health Care to release information requested by insurance company and/or its representatives. I am aware that the practice of medicine is not an exact science, and no one has any guarantees regarding the results of treatments, examinations and/or procedures. I fully understand this agreement and consent will continue until cancelled by me in writing. My signature indicates that I am giving my consent to treatment.

My signature acknowledges that I was provided with a copy of Continuum Health Care's **Notice of Privacy Practices** (HIPPA). I fully understand this agreement and consent regarding my protected health information will continue until cancelled by me in writing.

X_____ _____

Signature of Patient Date

_____

Print Patient Name

Cancellation Policy

To meet the needs of all our patients, we appreciate you understanding regarding the necessity to have appropriate notice. If you cannot come to your scheduled appointment, we require a 24-hour notice. Failure to cancel or reschedule your appointment within a 24-hour notice will result in a $25 fee. All no-show appointments will result in a $30 fee. This fee will be added to your bill.

Return Check Policy

We reserve the right to verify adequate funds prior to accepting a check. A $30 fee will be charged for any returned check.

Payment for Service

Any co-pays, additional fees, or cash payments are due at the time of service.

Late for an appointment

If you are unable to arrive at your appointment on time we appreciate your courtesy in letting us know as far in advance as possible. Please understand that we reserve the right to reschedule your appointment to a future date if you are more than 15 minutes late for your appointment.

Your signature indicates your understanding of the above-mentioned policies

X_____ _____

Signature of Patient **Date**

_____

Printed Name