TOTAL FAMILY CARE

CONSENTS AND NOTICES

IMPORTANT: Please read carefully.
Initial each line to indicate that you have read the statement

_____ **CONSENT FOR MEDICAL SERVICES & TREATMENT**

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by the physicians and ancillary providers of Total Family Care and/or its designee(s).

_____ **NOTICE OF APPOINTMENT POLICY**

CANCELLING OR RESCHEDULING:

You must give our office at least 24 hour notice when cancelling or rescheduling an appointment. Appointments that are cancelled or rescheduled with less than 24 hour notice will result in a $25 charge to the patient. You can call, or **text**, us to let us know as long as it is the day before.

_____ **LATE ARRIVAL POLICY:**

If you arrive more than 10 minutes late for your scheduled appointment time, we must reschedule your appointment and you will be charged a $25 No-Show/rescheduling fee.

_____ **MISSED APPOINTMENTS:**

For missed appointments, resulting from a No-Show or a late arrival (> 10 minutes), you will be charged a $25 No-Show fee.

_____ Insurance companies **DO NOT** pay for missed/cancelled/rescheduled appointment fees. I understand and agree to all of the Notice of Appointment Policies.

_____ **NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices or have been directed to a copy of the same and that it was explained to me.

_____ _____

Patient/Guardian Name – Please print **Date**

_____ _____

Patient/Guardian Signature **Date**