Co-payments and Deductibles: Payments is required for all services at the time they are rendered. All applicable co-payments and deductible will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balance owing that are past due. I further acknowledge that I am responsible for the coinsurance and/or deductible under my health plan's agreement and should Reflect Medical & Cosmetic Center be required to send me to a collection agency, I shall be responsible for 30% fee added to the outstanding balance. Your signature below signifies understanding of this policy.

Patient Signature: _____ Date: _____

Referrals: If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, Reflect Medical & Cosmetic Center **will reschedule** my appointment.

Insurance Cards: All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance, coordination of benefits or contact information.

Patient Signature: _____ Date: _____

Cancellation Policy: Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 24 hours of the appointment will result in a $35.00 no-show fee. This fee is not reimbursable by your insurance company.
** Suboxone Program patients will be charged a $50.00 no-show fee for failure to notify our office within 24 hours of their visit.

Patient Signature: _____ Date: _____

HIPPA Policy: Patient 18 years of age or older are protected under the Federal Health Insurance Portability and Accountability Act. This federal law prohibits any staff member of Reflect Medical & Cosmetic Center from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition, obtain results or appointments for you, please list their name(s) below. Only individuals names listed will be provided with information. Should you wish to update the names provided, please ask patient service representative at the front desk for a HIPPA form.

- May only speak to me _____ May email me at:_____
- May leave detailed message on the following phone number: _____
- You may speak to: _____(Name/Relationship) regarding my medical concerns.

Acknowledgement: I acknowledge having received a copy of Reflect Medical & Cosmetic Center Notice of Privacy Practice related to the Health Insurance Portability and Act of 1996.

Patient Signature: _____ Date: _____

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian: I certify that the information that I have provided is correct. I hereby assign to Reflect Medical & Cosmetic Center, any insurance or third party payment for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Print Name:_____Date:_____