

HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

By signing below, I hereby acknowledge the receipt of FORTÉ SPORTS MEDICINE AND ORTHOPEDICS Notice of Privacy Practices.	
PRINT NAME:	
SIGNATURE:	
DATE:	
FOR OFFICE USE ONLY:	
Good Faith Effort was used to obtain acknowledgemer	nt, but despite this effort, the
Patient Refused	
Patient Unable Due To:	
Staff member's signature:	
Date:	
Thank you for trusting your medical needs to Forté Spoappointment, we set aside time to provide you with the reschedule or cancel an appointment, contact our offic appointment. This policy is in effect from January 1st to Show/Cancellation Policy below: 1. Any established patient who fails to show or ca appointment will be considered a no show. The 2. Any established patient who fails to show or ca second time will be considered a no show, 2nd of directly to you, not to insurance. 3. Any established patient who fails to show or ca 3rd time will be considered a no show, 3rd occur directly to you, not to insurance. You will be bl both no show fees have been paid.	the highest quality of care. Should you need to be no later than 24 hours prior to your scheduled to December 31 st each calendar year. See our No incel an appointment 24 hours prior to a scheduled ere is no charge for the 1 st occurrence. Incel an appointment without a 24-hour notice for the occurrence. You will be charged \$25.00. This is billed incel an appointment without a 24-hour notice for the orence. You will be charged \$50.00. This will be billed ocked from scheduling any future appointments until en emergency occurs and you may not be able to keep the extenuating circumstances, please contact our Front
I acknowledge that I have been made aware of the No	-
3	•
Signature (Patient or Parent/Legal Guardian)	Relationship to Patient
Printed Name	Date

*Refusal to sign the acknowledgement of the policy does not exempt you from our company policy.

Patient Refused: _____ Date/Time: _____ Staff Witness: _____