Signature Page

*****Please <u>print</u> this page, <u>review</u> the contents thoroughly, <u>sign</u>, and <u>bring</u> with you to your firstappointment.*****

I. Consent for Treatment

I authorize Dr. Jennifer Wallace to provide ongoing medical care, treatment, and procedures as needed. I understand that no guarantees can or will be made as to the results of care, treatment, or medication prescribed.

If the patient is a minor, the parents or legal guardians **as well as those listed below** may accompany minor to visits and/or consent for medical care:

____

II. Financial Agreement

I understand and agree that I am financially responsible for all services provided. As a courtesy, Dr. Wallace will bill my insurance carrier. Co-pays are due at the time of service. Dr. Wallace will notify me via email of any additional payments needed for coinsurance, deductible, or non-covered services. Full payment is due within 30 days of such notification. Any outstanding balances more than 30 days overdue will incur a fee of $15 per month. If collection procedures are required, I am responsible for their cost.

III. Assignment of Benefits

I authorize my insurance benefits to be paid directly to Jennifer Wallace MD. I certify that all information given in applying for payment under my health insurance plan is correct, and I authorize verification of coverage by Dr. Wallace. A photocopy of this authorization shall be considered as effective and valid as the original.

IV. Consent to Release of information

I authorize Dr. Jennifer Wallace to release upon request to my insurance carriers or other reimbursing agencies information about my identity, treatment, diagnosis, prognosis, and/or other services rendered including information about substance abuse, HIV/AIDS, or other sexually transmitted or reportable diseases as permitted by law, thus releasing Dr. Jennifer Wallace of any liability for furnishing such information. I understand that information may be released through electronic or paper media.

V. Notice of Privacy Practices (HIPAA)

I acknowledge that I have been provided with access to or a copy of the Notice of Privacy Practices (on website).

VI. Approved Methods of Communication: (please circle your choices)

I **DO/DO NOT** consent to the leaving of voice mail regarding medical results, appointment reminders, or billing issues.

I **DO/DO NOT** consent to the leaving of e-mail regarding medical results, appointment reminders, or billing issues.

VII. Acknowledgement of Practice Policies

I hereby acknowledge that I have reviewed or will immediately review the practice policies as posted at www.jwallacemd.com and agree to abide by these practice policies while under the care of Dr. Jennifer Wallace. This includes, but is not limited to, policies on missed appointments, narcotics, and refills.

Signature of Patient/Guardian:____**Date:**________________

Printed name:____