

NOTICE OF NO SHOW POLICY ACKNOWLEDGEMENT

I understand that Carolina Pediatric Group has a NO SHOW Policy. The policy is in effect to assist with the scheduling of patients. After three missed appointments my child may be dismissed from the practice. A fee of \$25.00 will be charged for any appointment missed.

NOTICE OF TELEPHONE CONSUMER PROTECTION ACT

In order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include pre-recorded/artificial voice messages and/or us of an automatic dialing device, as applicable.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand Carolina Pediatric Group's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Carolina Pediatric Group, P.A. restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Carolina Pediatric Group, P.A. is not required to agree to my requested restrictions, but if Carolina Pediatric Group, P.A. does agree then Carolina Pediatric Group, P.A. is bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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