



1811 Virginia Avenue, Harrisonburg, Virginia 22802
(540) 442-8294

HIPAA Office Policy

- I understand that this office operates under the HIPAA compliance act and I don't need to read that act.

- I understand that this office operates under the HIPAA compliance act and I have been able to read the act on file in the office

Signature: _____ Date: _____

Office Policy

(PLEASE READ AND SIGN BELOW)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager.
- If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account. Balance older than 60 days will accrue interest charges of 1.5% per month, plus any attorney fees, court cost and collection fees.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes in my medical status.
- I agree to allow my name and/or likeness to be posted in this office.

Signature: _____ Date: _____

Social Security Number: _____