

CHARLOTTESVILLE WELLNESS CENTER  
*FAMILY PRACTICE*

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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE**

By signing below, I am acknowledging that I have been provided with a copy of Charlottesville Wellness Center Family Practice Privacy Notice pursuant to the Federal regulations known as the HIPAA Privacy Rule.

Patient Name: (Print) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient (Sign) \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Consent to Share Information**

To protect the confidentiality of our patients, we ask you to fill out this form. If you do not let us know who we may talk to, we will not discuss your medical care with them.

People we **MAY** talk to about your medical care:

Name/Relationship


**Parental Consent for Child Under 18 Years of Age:**

I give my consent to the Physicians and Nurse Practitioner to see and treat my child as indicated. If his/her condition requires follow-up, I give permission for continued office care in my absence. (No invasive procedures will be performed without direct notification to the parent).

Signature of the Parent or Guardian: \_\_\_\_\_

**Acknowledgment of our Financial Policy**

We accept most insurances. Please be aware that some or perhaps all of the services rendered may not be covered. If your insurance company denies payment, you will be billed with payment in full due upon receipt. Payment assignment must be made to this office. If you wish to be reimbursed by your insurance company, payment in full is due at the time of service. Co-pays, deductibles and payment for non-covered services are due at time of treatment. We accept cash, checks, debit cards and major credit cards. Should it become necessary to utilize outside collection means for past due accounts, you are responsible for all costs including but not limited to attorney, court and collection fees. A minimum \$25.00 fee will be assessed on all return checks.

I have read and understand the Financial Policies of the Charlottesville Wellness Center Family Practice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_