FAIRFIELD DERMATOLOGY

Acknowledgement of Receipt
Of Notice of Privacy Practices (HIPAA)

I acknowledge that I have had an opportunity to review this medical practice's Notice of Privacy Practice. I further acknowledge that copies of the current notice will be available in the office reception area.

Sign : _____ Date: _____

Printed Name: _____

Name(s) of person(s) and their relationship you authorize to participate in your medical care:

1. _____
2. _____

Cancellation Policy

Thank you for booking your appointment with us. As a courtesy we call our patients to confirm upcoming appointments. However if an appointment needs to be rescheduled or cancelled, it is the patient's responsibility to notify the office with a minimum of 24 hours' notice. **If our office has not received notice to cancel or reschedule your appointment within the required 24 hours, you will be billed accordingly, per this financial agreement.** ***Your health plan does not cover payment for missed appointments; therefore , you are responsible for this payment in full.*** Please help us better serve all of our patients by notifying us as soon as possible if you must change or reschedule your appointment.

Cancellation fees:
Office visit : $25
Surgical excisions: $50
Chemical peels/Microdermabrasion: $50
Laser procedure: $100
Other cosmetic appointments (fillers, sclerotherapy): $100
Fraxil CO2 laser: $500 (requires 48 hours' notice for cancellation)

My signature confirms that I have read and understand the cancellation policy and financial agreement of this practice. I agree to abide by these policies and agreements and fulfill my responsibility under this agreement.

Sign: _____ Date: _____