San Marcos Family Medicine

I hereby assign, transfer, and set over to San Marcos Family Medicine,P.A., all of my rights,title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

- **ALL COPAYMENTS OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE**
- **WE ACCEPT: CASH, CHECK, MASTERCARD, VISA, AMERICAN EXPRESS AND DISCOVER**

Patient Signature _____ Date _____

Acknowledgement of Receipt of Privacy Practices

I, _____, have received a copy of of San Marcos Family Medicine, P.A.'s Notice of Privacy Practices with an effective date of April 13, 2003.

Patient Signature _____ Date _____

Missed Appointment Fee Notice

San Marcos Family Medicine strives to accommodate all our patients in a timely manner. We schedule our appointments so that each patient receives the right amount of time to be seen by our providers and staff. Because it is important that you keep your scheduled appointment with us, we will send courtesy appointment reminders at the time you schedule your visit, 3 days prior to your visit, and again the day before your visit. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. We require a minimum notice of **24 BUSINESS** hours for cancellations or rescheduled appointments and are unable to make schedule changes after hours or during the weekend. If you do not provide appropriate notice for a cancellation or rescheduled appointment, we will require a $40 "no-show" service charge prior to scheduling any future appointments. This "no-show charge" is not reimbursable by your insurance company and will be your sole responsibility. For failure to provide appropriate notice for a cancellation or rescheduled appointment after the initial "no show", we will require a $100 "no-show" service charge and a $200 deposit prior to scheduling any future appointments. Patients who fail to provide appropriate notice beyond this point may be subject to dismissal from the practice.

I understand the "no-show" policy of San Marcos Family Medicine. I understand that I must cancel or reschedule any appointment at least **24 BUSINESS** hours in advance in order to avoid a potential no-show charge to my account.

Patient Signature _____ Date _____

Thank you,
San Marcos Family Medicine