HIPPA PRIVACY
Notice of Privacy Practices
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read the provided copy of Dr. Greg Wacasey's Notice of Privacy Practices.

Patient's name_____

Signature of Patient _____
(Or Patient's Legal Representative)

Date _____

Missed Appointment and Cancellation Policy

IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, PLEASE GIVE A 24 HOURS ADVANCE NOTICE TO ENSURE THAT YOU WILL NOT BE CHARGED FOR THE APPOINTMENT.

IF LESS THAN 24 HOURS NOTICE IS GIVEN AND WE ARE UNABLE TO FILL YOUR TIME SLOT, YOU WILL BE CHARGE A 50.00 CANCELLATION/NO SHOW FEE.

THANK YOU.

SIGN_____

DATE_____