



PATIENT INFORMATION

Last Name, First Name: _____

Date of Birth: _____

Home Address: _____

E-mail:

(ONLY if wish to receive your private patient related information, this is not HIPPA compliant form of communication):

Phone #: _____

PLEASE INDICATE IF YOU WISH TO RECEIVE YOUR PRIVATE PATIENT RELATED INFORMATION ON THIS PHONE NUMBER, ***THIS THIS IS NOT HIPPA COMPLIANT FORM OF COMMUNICATION !***

YES, SEND _____

NO, DO NOT SEND _____

Pharmacy Address: _____

EMERGENCY CONTACT/ SHARE YOUR MEDICAL INFORMATION:

Name: _____

Relationship to Member: _____

Phone # : _____

Signature

Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 01/01/2020.

Signature of Patient/Patient Representative

Date

Relationship to Patient

Missed Appointment Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our office, but our other patients as well. Please be aware of our policy regarding missed appointments.

_____ Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call Dr. Olga Aleksandrova as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least **12 hours** in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

_____ How to Cancel Your Appointment

If you need to cancel your appointment, please call us at **(407)717-4400** . If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

_____ Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than **12 hours** before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **\$75 missed appointment fee**.

_____ For **new patients' first appointments**, a no show or late cancellation will result in a **full charge** of the new patient fee.

Patient name (Signature) : _____

Date: _____