



- ❖ *Ann Arbor Neurology*
- ❖ *Associates in General & Vascular Surgery*
- ❖ *Cardiovascular & Thoracic Surgeons*
- ❖ *Huron Valley Urology Associates*
- ❖ *Pathology & Laboratory Mgmt. Associates*
- ❖ *Pulmonary & Critical Care Associates*

Patient Name (Please Print)

Date of Birth

NG# (Office Use Only)

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Michigan Multispecialty Physicians, PC (MMP) Notice of Privacy Practices.

Initial: _____

NO-SHOW/CANCELLATION POLICY

It is the policy of all MMP offices to encourage patients to arrive and receive care at their scheduled arrival time, or to give appropriate notice of cancellation to allow other patients to receive timely care.

If you are unable to make your scheduled arrival time, we request that you notify us as soon as possible, but no later than 24 hours prior to your scheduled arrival time. Additionally, we request that you arrive at your scheduled arrival time.

By either not providing 24 hour notice or arriving late, you may be assessed a \$25.00 fee for a missed office visit or \$50.00 fee for any missed procedures. All no-shows and cancellations with one MMP office will be combined with no-shows and cancellations from other MMP offices. If three (3) or more appointments are missed, all offices within MMP reserve the right to terminate our relationship with you. A list of MMP offices can be found at the top of this form.

It is not our intent to assess an additional financial burden, but it is costly if you miss your appointment and do not give us time to schedule another patient in your time slot.

Initial: _____

RECEIPT OF PATIENT FINANCIAL POLICY

It is the policy of MMP to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstandings or disagreement concerning payment for professional services.

I have read and understand the MMP Patient Financial Policy and I agree to be bound by its terms. I also understand and agree that MMP may amend such terms from time to time.

Initial: _____

Patient/Guardian Signature

Date