Horizon Balance and Dizziness Center

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| Patient Name:(last, first, mi) | Date of Birth(mm/dd/yyyy) |
| **Welcome to Horizon Balance and Dizziness Center.**  **Release of Information and HIPAA/Privacy Acknowledgment: Horizon is required by law (Office of Civil Rights) to protect the privacy of your medical records. Horizon Balance and Dizziness Center uses and discloses medical records ONLY in accordance with state and federal privacy laws(HIPPA). As a patient of Horizon Balance you have the following rights regarding your healthcare information:**   1. **The right to access, inspect, copy and amend his/her own records. 2. The right to receive a listing of all information disclosures upon request. 3. The right to file a complaint with the practice and or the Department of Health and Human Services if you feel that your privacy rights have been violated.**   **I understand and agree that a $25.00 fee will be assessed if I do not provide a cancellation notice before the end of the business day prior to a scheduled appointment. This fee will not be billed to or paid by your insurance and must be paid prior to receiving the next appointment**  **Financial Responsibility:**  **I (Patient or Authorized Representative) agree to pay for any amounts not paid by an insurance company or other third party payer for care provided. I understand that I am responsible for all co-payments, deductibles, co-insurance, and/or non-covered service.**  **Unresolved Account Balances:**  **I understand that interest does not accrue and statements are not mailed to me until after my insurance(s) has paid and I am left with a balance. I understand and agree that any remaining balance on my account not paid within 30 days of the statement date a finance charge of 1 ½% per month(annual percentage rate 18%)of the unpaid balance will be added monthly. I understand that my balance will be sent to a collection agency if I choose not to pay for care provided. In the event an unpaid balance is placed with a collection agency or attorney, I agree to pay the unpaid balance (including interest) and a collection fee of up to 40%, in addition to all related attorney fees and court costs.**  **Assignment of Benefits:**  **I request and authorize my health insurance carrier to Pay Horizon Balance and Dizziness Center directly for all charges related to services provide to me.**  **My Signature below acknowledges that I have read, understand, and agree to the terms of this authorization form and give my consent to proceed with my treatment.**  **I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing by the Patient or Authorized Representative:**   |  | | --- | | Signature: Date: | | |