Patient_____ Date of Birth_____/_____/_____

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been made aware of Ohio Pain & Rehab Specialists Practice Policy to disclosure information.

In the course of patient care, occasionally it may be necessary to leave a message on your voicemail or answering machine at home, work, or on your cell phone. These are numbers that we ask you to provide so that in the event of an urgent need, we may have alternatives to reach you. Your response to the preference below will apply to all alternatives we have at our disposal to contact you.

PLEASE CHECK ONE PREFERENCE BELOW

I authorize Ohio Pain & Rehab Specialists, and its employees and affiliates to leave a detailed message regarding my appointment, prescription, and/or financial account information on my recorder/voicemail:

YES [ ] **NO [ ]**

I hereby authorize Ohio Pain & Rehab Specialists to furnish information to _____. Relationship_____

I understand that this authorization will be in effect until I have notified Ohio Pain & Rehab Specialists in writing to withdrawn this authorization.

OFFICE VISIT AND OFFICE PROCEDURE CANCELLATION AND NO-SHOW POLICY

As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a Cancellation Policy.

Time has been specifically reserved for your fluoroscopy treatment. Please call at least 24 hours ahead to cancel or reschedule an appointment.

If you fail to cancel your office appointment at least 24 hours ahead or fail to show up for your scheduled appointment, you will be charged a “No Show Fee.” The fee is $50.00 for established patients and $100.00 for a consultation or new patient visit. If you fail to cancel or show for your spinal injections, fluoroscopy, Botox or EMG, you will be charged a $250.00 “No Show Fee.”

UNFORESEEN CIRCUMSTANCES

We recognize that situations can occur which are unforeseen and as such the following procedure is required in order to waive the “No Show Fee.”
llness: Must provide Emergency Room Report or Physician Excuse.

I have read and understand the above policies.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____