ACKNOWLEDGEMENT OF RECEIPT

Joint Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of D&G Medical Associates Joint Notice of Privacy Practices on the date indicated below. If you have any questions regarding the information contained in D&G Medical Associates Joint Notice of Privacy Practices, please contact the office at (208) 286-8670.

AUTHORIZATION TO TREAT AND FINANCIAL AGREEMENT

I authorize D&G Medical Associates to perform procedures and provide medical care that is deemed medically necessary. I also agree that the insurance information that I have provided on the new patient paperwork is true and accurate. I understand that D&G Medical Associates will be billing my insurance for medical visits and procedures as they occur. I understand that I am financially responsible for any expenses that are not covered by my insurance carrier such as, but not limited to: non-covered insurance benefits, co-insurance, co-pays and deductibles, collection fees, and any additional fees associated with the collections process. I agree to pay D&G Medical Associates any of these fees at the time of my appointment unless I have made other arrangements in writing. My signature below shows understanding of this information.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____