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Privacy Notice Acknowledgement

I am very concerned with protecting the privacy of your personal health information. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that your health practitioner supply you with a copy of their privacy policies and procedures.

Any information in your file will only be given to you, a doctor, or other organizations (health insurance company, lawyer, etc) that you have authorized to see this information. Any requests for your file or information will first be referred to you for authorization. I do not mail, FAX or otherwise electronically transmit information unless authorized by you to do so. If you have any questions or concerns regarding the use or dissemination of your personal health information, please contact me.

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for Protected Health Information.

Patient Name Printed

Signature

Date

Payment Policies

As your practitioner I have set aside adequate treatment time to address your concerns. Please honor your appointment time. **If you are unable to meet your appointment, please call 24 hours before your scheduled time (except in an emergency), otherwise you will be responsible for full payment of that visit.**

Payment can be made by check, cash or credit card, and is expected at date of service. Fees associated with returned checks will be your responsibility.

I acknowledge that I am aware of these payment commitments:

Patient Name Printed

Signature

Date