Mukilteo Natural Health Clinic

Practice Information and Patient Responsibility Agreement

We ask that every patient please read and agree to the following:

- **Please be prepared to provide identification and insurance card at the time of each visit.**
- Each practitioner operates individually as a private practice. Practitioners maintain separate charts, registration forms, insurance information, monies, etc. Updating your information for one practitioner does not update the chart of any other practitioner.
- **Each patient is responsible for knowing the terms and coverage of their own insurance plan**. If you have insurance and your practitioner "accepts" that insurance, that does not guarantee payment will be made from your insurance company. You are then personally responsible for the bill.
- Payment for dispensary items and co-pays needs to be completed at the time of service. **Exact change, check or Visa/MasterCard is required.**
- Mukilteo Natural Health is a **fragrance-free facility** and only allows service animals in the building. Please help us maintain an allergy free environment.

APPOINTMENT CHANGES: Please notify us within 24 hours if you need to cancel or reschedule you appointment to avoid a $45 fee. If there is a valid emergency, we will make every effort to accommodate you.

I have read the policy above, and I understand and agree to it.

Printed Name:____________________ Signature:____________________ Date:____________

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your practitioner.

Our **Notice of Privary Practices** describes in more detail how your health information may be used or disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

______________________________ ________________________

Patient or legally authorized signature — Date

______________________________ ________________________

Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, representative)