I understand and agree that if my check is dishonored or returned for any reason, check plus will electronically debit my account for the amount of the check plus a processing fee of $25.

_____ _____
Signature Date

I understand I will be charged and agree to pay a fee of $25 if I do not cancel my appointment 24 hours prior to the appointment.

_____ _____
Signature Date

I understand and agree that all copayments are to be paid prior to seeing the doctor, and if I failed to pay my copayment at my appointment maybe reschedule to another date.

_____ _____
Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of Pinnacle Healthcare systems notice of privacy practices.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name Name and Relationship of Personal Representative

PATIENT'S SIGNAURE RELEASE AUTHORIZATION AND STATEMENT OF FINANCIAL RESPONSIBILITY

I authorize use of this form on all my insurance submissions. I understand that I am financially responsible for the charge is not covered by the assignment or for any and all charges which the insurance carrier declines to pay. I authorize payment directly to Pinnacle Healthcare System.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name Name and Relationship of Personal Representative

PATIENT'S RELEASE TO VIEW MEDICATION HISTORY

One of the features of electronic prescribing systems is that it allows us to view medications that have been electronically prescribed to you by other physicians. This improve patient safety by helping us avoid prescribing medication that might interfere with what you were already taking. By signing below, you authorize us to review your medication history.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Patient's Name Name and Relationship of Personal Representative