Please submit this form to:
HIPAA Privacy Officer/Compliance Officer
13359 Isle Drive, Suite 1
Baxter, MN 56425

Kurtis A. Waters MD PA

Receipt of Notice of Privacy Practices Written Acknowledgement Form

Note: You May Refuse to Sign This Acknowledgement

PATIENT INFORMATION

1, _____(patient name), understand that I may request a copy of the Notice of Privacy Practices. It is also available to me on the website, www.kurtiswatersmd.com

Signature of Patient:_____Date:_____

See Back for Financial Policy-need signature

FOR INTERNAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify) Specify_____

Financial Policy

This is an agreement between Kurtis Waters, MD, PA, as creditor, and the patient/debtor named on this form. In this agreement, the words "you," "your," and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Kurtis Waters, MD, PA.
By executing this agreement, you are agreeing to pay for all services that are received.

Benefits:
- It is patient responsibility to verify any and all coverage, eligibility, and benefit levels per their individual insurance policy(s). We are unable to quote any benefits and/or allowed amounts for your visit. Please contact your insurance company directly with any policy concerns.

Policy for non-insured medically necessary procedures:
- Payment in full is due on the date that services are rendered.
- Patient will receive a 30% discount of normal fee rates for same day payment.

Policy for patients with contracted and non-contracted insurance companies:
- If we are contracted with your insurance company, we must follow our contract and their requirements.
- Any co-pays required by your insurance company must be paid at the time of service. This is an insurance requirement per your policy. You agree to pay any portion not covered by your insurance.
- It is the insurance company that makes the final determination of your eligibility.
- If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral may result in a lower payment from your insurance company.

Policy for Cosmetic Procedures:
- Payment in full is required on the date of service for all injections and cosmetic consultations. No same day discount applies as cosmetic procedures are already set at a discounted rate.
- Payment for a scheduled cosmetic surgery must be received 14 days prior to the date of surgery. If this payment is received after that date, surgery may be rescheduled from 14 days of receipt of payment.

Statements:
- You will receive a statement on any remaining balance after we receive notification from your insurance company.
- BALANCE IN FULL is due upon receipt of statement.

Returned Checks:
- Any checks returned by your financial institution will be assessed a fee of $35.00.

Past due accounts:
- If your account becomes past due, we will take any and all necessary steps to collect this debt. If we refer your account to an outside collection agency, all future correspondence regarding that debt will need to be made directly through the collection agency.
- We reserve the right to cancel your privileges to make charges against your account at any time due to delinquent balances.
- If a balance remains unpaid, any future care you may need by our office could be affected.

Waiver of confidentiality:
- You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Record Release:
- I authorize Kurtis Waters MD, PA to release medical information about me to my insurance carriers, the Social Security Administration or its intermediaries/carriers, Centers for Medicare & Medicaid Services (CMS) and its agents for purposes of payment, and to referring physicians and other providers involved in my care.

Assignment of Benefits:
- I authorize payment of Medical/Medicare benefits to Kurtis Waters MD, PA for any services furnished by this clinic to me. I understand that I am financially responsible for charges not covered by Medicare and/or my insurance carriers. This authorization also covers charges generated by Kurtis Waters MD, PA for services received at Essentia St. Joseph's Medical Center or other medical facilities.

Effective Date:
- Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. I permit a copy of this authorization to be used in place of the original.

Patient's Name: _____

Responsible Party: _____
(If not the patient)

Signature: _____ Date: _____