

# John K. Miller, L.Ac

51 East 42<sup>nd</sup> Street \* Suite 304 \* New York NY 10017 \* (917) 645-6411

## SERVICES AND FEES

Any appointments missed or cancelled with less than 24 hours notice will incur the full service fee billed to your account.

John K. Miller, L.Ac reserves the right to cancel patient appointments due to inclement weather or other emergencies. In the event of an office closing, patients will be given as much notice as possible, and will not be charged for their appointment.

Late arrivals will be charged the full fee, and may have an abbreviated treatment.

John K. Miller, L.Ac reserves the right to refuse treatment for inappropriate conduct, lack of payment or late payment of fees, medical reasons, safety concerns, or other reasons as determined by him.

I have read the above and agree to pay the fees listed at the time of service. I understand that if I miss an appointment or cancel with less than 24 hour notice I will pay for that visit. \_\_\_\_\_ (Initial)

**If we are billing your insurance company directly, please be advised that any fee related to deductibles, co-insurance, co-pays and claims denied will be billed to your account.** \_\_\_\_\_ (Initial)

I hereby authorize payment of medical benefits directly to John K. Miller, L.Ac for all services rendered. \_\_\_\_\_ (Initial)

I hereby authorize John K. Miller, L.Ac, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment.

\_\_\_\_\_ (Initial)

CREDIT CARD TYPE: \_\_\_\_\_

CREDIT CARD #: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

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SIGNATURE

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how the health data about you may be used and shared and how you can get access to this data.

- I. How we may use and share health data about you:
  - a) Treatment – To give you medical treatment or other types of health services.
  - b) Payment – To bill you or a third party for payment for services provided to you.
  - c) Health Care operations – For our own operations such as quality control, compliance monitoring, audit, etc.
  
- II. Disclosures where we do not have to give you a chance to agree or object:
  - a) To you
  - b) As required by a federal, state, or local law
  - c) If child abuse or neglect is suspected
  - d) Public health risks (for public activities to prevent and control spread of disease)
  - e) Lawsuits and disputes (in response to a court or administrative order)
  - f) Law enforcement (to help law enforcement officials respond to criminal activities)
  - g) Coroners, medical examiners and funeral directors
  - h) Organ or tissue donation facilities if you are an organ donor
  - i) To avert a threat to an individual or to public health safety
  
- III. Disclosures where we have to give you a chance to agree or object:
  - a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
  - b) Persons involved in your care or payment for your care – We may share your health data with your family member, a close friend, or other person that you have named as being involved with your health care.
  
- IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.
  
- V. You have the following rights relating to health data we keep about you:
  - a) Right to inspect your health record and to receive a copy upon request
  - b) Right to amend information in your health record you believe is inaccurate or incomplete
  - c) Right to know to whom we have disclosed your health information
  - d) Right to ask for limits on the health information data we give out about you
  - e) Right to receive communication from us about your health information in alternate ways
  - f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the **NOTICE OF PRIVACY PRACTICES** of this practice.

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Signature of patient or representative

Date

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Print patient name

Patient Birth Date