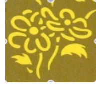

# HILL FAMILY MEDICINE & SKIN CARE

Dr. Svetlana Megley Hill, MD Dr. Matthew S. Hill, DO
Board Certified Family Medicine Doctors

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www.hillfamilyclinic.com

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**
I have reviewed Hill Family Medicine & Skin Care's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.
Patient/Guarantor Signature:_________________________________Date:________________________
Name of Patient or Personal representative:__________________________________________________
Description of Personal Representative's Authority:___________________________________________

**Hill Family Medicine & Skin Care Revised Medical Care Agreement**
I authorize the physicians of Hill Family Medicine & Skin Care to administer medical treatment as deemed necessary. I understand that there will be a $25.00 charge for all missed appointments and appointments not cancelled 24 hours in advance, and if I am more that 15 minutes late to an appointment I may be subject to being rescheduled. I understand that the primary insured is financially responsible for any balance not covered by my insurance including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits to otherwise payable to me to Hill Family Medicine & Skin Care.

**Security of Patient and Public Personal Property**
I understand and agree that Hill Family Medicine & Skin Care is not responsible for the security and protection from loss or theft of my personal property while on its premises (including the parking lot and other contiguous areas outside the building) and further understand and agree I am personally and directly responsible for security of all my personal belongings including without limitations articles of clothing, purses, wallets, cash, jewelry and personally owned equipment.

**Financial Responsibility, Assignment of Benefits, Authorization to Release Medical Information:**
I hereby authorize the physician to release information in connection with my treatment to my insurance company, employer, their representative, or referring physician at such as information is requested. I authorize assignment of benefits to my physician. Additionally I gave my permission to Hill Family Medicine & Skin Care and staff to release medical information contained in my medical file about myself to those indicated below.
Name:__________________________________ Relation to Patient:________________________________
Name:__________________________________ Relation to Patient:________________________________
Name:__________________________________ Relation to Patient:________________________________

I have read and agree to all of the above information:
Patient/Guardian Signature___________________________________________________________________