

**PATIENT ACKNOWLEDGEMENT**

**NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices. I have read and understand this practice's Notice of Privacy Practices, which provides information on the uses and disclosures of my protected health information.

Name of patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Print)

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

**BILLING POLICY STATEMENT**

All payments are due at the time of each visit. If you need to cancel an appointment, you must give at least 48 business hours of advance notice. Business hours are weekdays from Monday through Friday and exclude all standard holidays. For example, if you have an appointment on a Tuesday at 4:00pm, you would need to cancel by the previous Friday at 4:00pm. Notification must be done via telephone (as emails may not be received). Should you cancel within less than 48 hours of the designated time or fail to appear for an appointment, you will be charged the following rates:

- \$300 for a 50 min scheduled appointment
- \$150 for a 25 min scheduled appointment

Please note that insurance companies do not reimburse for missed sessions.

By signing below, I acknowledge that I have read and understand the billing policy of Yujuan Choy, M.D.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_