

Patient Acknowledgement of Office Policies & Procedures

I, _____ (print your name) provide this signature as acknowledgement that I have been presented with and have read and understood the Office Policies & Procedures information provided to me by High Ridge Family Practice, LLC. This includes but is not limited to the Patient Registration Form (2 sides), the Office Policies regarding Non-Covered Services, the Patient Responsibility List and the High Ridge Family Practice Responsibility to Patient's List.

I understand that any services not covered by my insurance will become solely my (the patient's) responsibility.

I agree to abide by the Office Policies and Procedures of High Ridge Family Practice.

Signature of Patient or
Legal Representative

Date

This form is valid until indicated by the above signee in writing
of other arrangements