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

1/2012