**Acknowledgement of Insurance Information**

**I certify that the insurance information which I have presented to you to file is current and that there is no other insurance company which is responsible other than what I have provided. I agree to notify A Step Ahead upon change of insurance any time during my care so that the correct insurance can be filed. If I fail to provide the correct insurance information and the claim does not get paid, I am aware that the balance of the allowable claim will be my responsibility to pay.**

**I understand that Insurance claims are filed as a courtesy. If the insurance claims are not paid within sixty (60) days of filing, then I will become responsible for the bill. I also understand that I am responsible for any co-pays, co-insurance and deductibles. I also understand that the insurance quotes provided are an estimate only. In the event that my insurance determines a service to be “non payable”, I will be responsible for the charges and agree to pay all costs. Should I fail to pay my bill or make payment arrangements within thirty (30) days, I will be turned over to a collection agency and be responsible for any and all collection costs.**

**I authorize A Step Ahead O & P to obtain/release any medical records needed by another medical provider.**

**Acknowledgement of Receipt of Notice of Privacy Practices**

I certify that I have received a copy of A Step Ahead O & P Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that might occur in my treatment, payment of my bills or in the performance of A Step Ahead O & P health care operations. The Notice of Privacy Practices also describes my rights and A Step Ahead O & P duties, with respect to my Protected Health Information. The Notice of Privacy Practices is posted on the office wall for all patients to review. A hard copy is also available to all patients.

A Step Ahead O & P reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. Patients may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient (please print) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Patient Representative Relationship to Patient