IKE B. GORMAN, D.P.M.
PHONE (520) 722-5115

SIGNATURE ON FILE

Please INITIAL all and sign below

_____ I wish to be contacted in the following manner (Please check all that apply):

Home Phone _____
____ Ok to leave message with detailed info
____ Leave message with call back number only
____ Ok to confirm appt at this number

Work Phone _____
____ Ok to leave message with detailed info
____ Leave message with call back number only
____ Ok to confirm appt at this number

_____ I understand that I am responsible for my bill. Any legal/collection fees obtained to collect the outstanding balance from the patient will be the responsibility of the patient and will be added to the balance due.

_____ I understand that if I don't show up to my appt or don't cancel my appt 24 hours in advance, I will be charged a $25.00 fee.

_____ I acknowledge that I was provided a copy of the Notice of Privacy Practice and that I have read (or had the opportunity to read it if I so chose) and understood the Notice.

_____ _____
Patient Name (please print) **Date**

_____
Parent or Authorized Representative (if applicable)

_____
Signature