Summary of Private Practices and Billing

1. We are required by federal law (HIPAA) to provide a notice of Privacy Practices that describes how health information that we maintain about you may be used or disclosed. This summary describes how your protected health information may be used or disclosed and how you may gain access to this information. Please review this summary carefully. A complete copy of these policies is available for review in our waiting room, please ask the doctor for assistance if this summary is not available to you. **I have received the summary of Private Practices from Dr. Anne Jacobs and I understand that by signing this document I acknowledge and agree with these privacy practices.**

Patient
Signature:______________________________________Date:____________

2. By signing below I give permission to Dr. Anne Jacobs to communicate with me via e-mail. I acknowledge the inherent privacy risks associated with electronic communication. I give permission for messages to be left on my voicemail or answering machine.

Phone number(s) to leave message on:________________________________

E-mail:____
Patient
Signature:______________________________________Date:____________

3. I give permission for the office of Dr. Jacobs to bill insurance on my behalf if appropriate.

Patient
Signature:______________________________________Date:____________

Patient's full name:____
(please print)

4. You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, supplements, prescription drugs, and equipment. Please request this personalized document if you would like a Good Faith Estimate to be provided before your visit.

Anne Jacobs, ND, LAc *www.drannejacobs.com*
Phone: 207-523-9247 *e-mail:anne@drannejacobs.com*