Wynne Huang, MD

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Acknowledgement of Financial Policies

I have read and understand the financial policies of Caring for All, P.C. I also agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any additional fees charged by the collection agency (due to the cost of collections), . I certify that I have provided the correct insurance information. I authorize the release of any medical information necessary to process the claim. I authorize payments to be made directly to Caring for All, P.C.

Patient Signature: _____ Date: _____

Acknowledgement of Privacy Practices

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communication
5. The right to a report of disclosures of your information, and
6. The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is listed on the last page of the Notice of Privacy Practice form.

"I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the last page of the Notice of Privacy Practice form. I further understand that the practice will offer me updates to the Notice of Privacy Practices should it be amended, modified, or changed in any way.

Patient/Representative Name (print): _____

Patient/Representative Signature: _____ Date: _____

☐ Patient refused to sign

☐ Patient was unable to sign because _____