Water and Grace Healing Space
PO Box #7, Hyde Park, VT 05655
P: (802) 610-2181
F: (844) 689-2490

Acknowledgement of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

We maintain a confidential record of the healthcare services provided to you. You may request to review or obtain a copy of this record, and you may also request corrections to ensure accuracy. We do not share your health information with others unless you provide written authorization, it is required for payment purposes, or it is otherwise permitted or required by law. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices.

_____ _____

Signature Date

_____ _____

Printed Name (if signed by representative) Relationship to Patient

Billing Release Acknowledgement

I understand that payment is due at the time of service for all visits unless prior arrangements have been made. If I provide insurance billing information, I remain financially responsible for all charges, regardless of whether my insurance pays. I authorize the release of any information necessary to process insurance claims, and I permit the use of my signature on all insurance submissions. If you have any questions regarding this policy, please let our staff know. By signing below, you acknowledge your understanding and acceptance of this policy.

_____ _____

Signature Date

_____ _____

Printed Name (if signed by representative) Relationship to Patient

Effective Date: _____