Daniel J. Walters D.P.M., P.C.
6545 W. Archer Avenue
Chicago, Illinois 60638
773-586-0050

Acknowledgement of Receipt of Notice of Privacy Practices

Daniel J. Walters DPM P.C. reserves the right to modify the privacy practices outlined in the notice.

_____ _____
Name of Patient (Print) Signature of Patient

_____ _____
Signature of Patient Representative Relationship of patient Representative to Patient

_____
Date

Office No Show Policy

Effective Date: the notice is effective on or after January 1, 2011.

We understand that there are often legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling in advance if you are unable to keep an appointment, as we would like to have the option to offer that appointment to another patient who needs to be seen.

This letter is to notify you that failure to provide a 24-hour advance notice of cancellation will result in a $25 cancellation fee. This will be billed to you directly and cannot be filed to your insurance company.

I certify that I have read, fully understand and received a copy of the above notification and that I have received clear explanation regarding the provided information.

Signed by

_____ _____
Signature of Patient/Legal Guardian Printed Name of Legal Guardian, if applicable

_____ _____
Printed Patient's Name Relationship to Patient

_____
Date