Acknowledgement

I have received a copy of the Notice of Privacy Practices.

I agree to receive treatment by Dr. Holladay/HolladayMD. I understand that no guarantee is being made as to a particular outcome. I understand that Dr. Holladay/HolladayMD may not be immediately available to address urgent matters by telephone, etc. If I am unable to contact Dr. Holladay/HolladayMD directly and there is an urgent matter, I understand and agree that it is my responsibility to seek help as needed – for example, from a primary care provider or an urgent care clinic. I agree to receive communications from Dr. Holladay/HolladayMD in any format (telephone, letter, email, text, etc.) and agree to request any changes to this in writing. I also agree that Dr. Holladay/HolladayMD may communicate regarding health-related matters with the person(s) listed as my emergency contact(s).

I agree to HolladayMD contacting and billing my insurance, if applicable, and agree to take appropriate responsibility for all charges. I also agree to cooperate promptly, as necessary, to help obtain insurance payment. I agree to communicate with HolladayMD if I decide to cancel or not show to an appointment.

_____
Patient signature

_____
Patient name

_____
Date