

LOUDOUN MEDICAL GROUP
Receipt of Notice of Privacy Practices Acknowledgement

I, _____, acknowledge receiving on
(print patient name)

_____, a copy of Loudoun Medical Group's Notice of Privacy Practices.

Patient Signature or Initials

LOUDOUN DERMATOLOGY ASSOCIATES

Missed Appointment Policy

To Our Patients:

Welcome to our office. We are pleased that you have chosen our practice for your dermatological needs. We would like to take this time to explain our office policies to you. If you have questions, please feel free to ask. Thank you.

Missed Appointments

Unless cancelled at **least 24 hours in advance**, it is our policy to charge missed appointments at the rate of **\$25.00 per appointment**.

If you miss more than two appointments without giving 24 hours notice, you will be discharged from the practice.

As a courtesy, we will continue to call and remind you of your appointment. However, it is your responsibility to keep the appointment or cancel at least 24 hours in advance.

I have read and agree with the above financial policy.

Signature

Relationship to Patient

Patient's or Guardian's Name

Date