# Alpine Medical Associates

Dr. Steven Brown practices Preventative Medicine and by doing so some services that he performs may not be covered by your medical insurance. As a courtesy to our patients, we bill your medical insurance for services rendered. However, if your insurance deems a service that Dr. Brown performs as "not a payable service" or "non covered benefit," the patient is ultimately responsible to pay the balance due.

By signing this form, I _____(patients name) acknowledge that I am financially responsible for any unpaid balance of services rendered by Dr. Steven Brown

Patient Initials _____

**HIPAA Privacy Policies**

Patient Name_____ Under HIPAA Privacy Policies, we are required by law to protect the privacy of your health information. We cannot disclose any health information about a patient without written consent. This includes speaking to or giving out information to any family member, including a spouse, children, or parents of children over the age of 18.

_____Relationship to Patient_____
_____Relationship to Patient_____
_____Relationship to Patient_____

Patient Initals_____

**No Show Appointment Agreement**

I understand that if I do not notify the office of Alpine Medical Associates within 24 hours of my schedules appointment, I will be charged a $25.00 no show fee. This fee will be due and payable before my next appointment with Dr. Steven Brown.

Patient Initials _____

Patient Signature_____