

# NEUROLOGIC CLINICS

Board Certified: Neurology/Psychiatry  
Hal Rappaport, M.D.

5606 14<sup>th</sup> Avenue NW, Suite 202, Seattle, WA 98107

PHONE: 206-782-4484

FAX: 206-782-4982

## Notice of Privacy Practices

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office staff.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient or legally authorized individuals' signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship

## Office Policies

I understand that I am financially responsible for all charges whether or not paid by insurance. Insurance coverage is not a guarantee of payment for services provided by my healthcare provider. It is my responsibility to understand my insurance benefits. Co-payments mandated by my insurance company may not be printed on my insurance card. I understand co-payments are due at the time of service. It is my responsibility to notify the receptionist upon arrival that a co-payment is due. If this is a motor vehicle accident and is not covered under your auto insurance we do not wait for a settlement for payment from a third party insurance. I have been informed that payment is due upon receipt of my monthly statement. Should I have NO insurance I understand that payment is due in full at the time of service.

A NO SHOW appointment without a one (1) business day notice is subject to a minimum \$25.00 fee.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date