Detweiler Family Medicine & Associates

1970 North Broad Street
Lansdale, PA 19446

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www.detweilerfamilymedicine.com

Office hours by appointment

Robert O. Detweiler, D.O.
Certified in Family Medicine
Michael T. Parke, D.O.
Certified in Family Medicine
Stephanie D. Shearer, D.O.
Certified in Family Medicine
Samara Martinez, D.O.
Certified in Family Medicine
Evan Kessler, D.O.
Certified in Family Medicine
Christine M. Sabatino, CRNP
Certified in Adult Health & Gerontology
Robert Davis, CRNP, DC
Certified in Adult Health
Wendy Brian, CRNP
Certified in Adult & Women's Health

Receipt of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Detweiler Family Medicine & Associates, PC. Our notice provides information about how we may use and disclose medical information that we maintain about you. We encourage you to read our full notice. If you have any questions about our *Notice of Privacy Practices*, please contact our designated Privacy Officer, Michael J Brown, at 215-368-1900 or by mail at 1970 North Broad Street, Lansdale, PA 19446, Attention Michael J Brown, Privacy Officer.

Printed Name:_____Signature:_____ Date:_____
Patient, Parent, or Personal Representative

If other than the patient, specify relationship:_____

Patient Communication Preferences

As our patient, we may need to communicate information to you pertinent to your health. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or others involved in your care.

I give permission to leave medical information pertaining to me, my dependant or child, at the numbers listed below:

Method	Yes	No	Tel# / Extension
Home			
Home Answering Machine			
Work Phone			
Cell Phone			
Email Address			Email:
Other, Specify _____			

Without permission, we will not release any medical information to anyone other than you. In some cases, you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e., spouse, parent, partner, etc.):

Name	Relationship	Tel# / Extension

I acknowledge that I am responsible to inform the practice of changes pertaining to my contact information and communication preferences. If I so desire, I may revoke this specific medical information authorization at anytime.

Statement of Financial Responsibility

In order to provide you with quality service at the best possible rates, we ask that patients agree to the following policy and sign below.

Detweiler Family Medicine will provide a service to you as agreed. That service has value. We ask that all bills be paid within 30 days of receipt. If more time is needed to resolve the invoice, we ask that you advise us accordingly at the time service is provided. If a bill remains unpaid for greater than 75 days, we may place the account into collections. If the account is placed for collection, the account holder will be responsible for any and all collection fees, including legal fees. Please note that failure to pay co-pay at time of service will result in a billing fee of $18.00. Furthermore, returned checks will be subject to a $30.00 fee. Additionally, we reserve the right to charge a fee of $45.00 when a patient misses a scheduled appointment without notifying our office in advance.

Printed Name:_____Signature:_____ Date:_____
Patient, Parent, or Personal Representative

If other than the patient, specify relationship:_____