**Anderson Orthopaedic Clinic**
**Receipt of Financial Policy and Notice of Privacy Practices**

Anderson Orthopaedic Clinic believes a clear understanding of our Financial Policy is essential to our professional relationship. If you have any questions or concerns, please do not hesitate to ask a member of our staff for clarification.

I have fully read, understand, and agree to comply with the terms of the Anderson Orthopaedic Clinic Financial Policy.

**Printed Name:** _____

**Patient Signature:** _____ **Date:** _____

I acknowledge that I have received a copy of Anderson Orthopaedic Clinic's Notice of Privacy Practices.

I give authorization to the following individuals to review or receive my Protected Health Information (PHI). I understand that this authorization remains in effect until specifically rescinded by me in writing.

**Name:** _____ **Relationship:** _____

**Name:** _____ **Relationship:** _____

**Name:** _____ **Relationship:** _____

**Patient Signature:** _____ **Date:** _____