EASTMAN & VEMPATI MD, P.C.

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- I hereby give Dr. Eastman, Dr. Vempati, Val Alef, NP and Sue Rice, NP my permission to examine and administer necessary medical treatment to my child/children _____ in my absence. (Names)

- I authorize the release of any medical records to process insurance claims on my behalf. I agree to be fully responsible for all lawful debts incurred for medical services by Eastman & Vempati MD, PC whether covered by insurance or not. I understand that I am responsible for knowing my insurance benefits and notifying us of any restrictions or maximums.

- We will verify that your insurance is in effect, but we can not verify what your benefits are. Verification that the policy is in effect does not guarantee payment. Your insurance is a contract between you and your insurance company.

- Co-pays must be paid at the time of the visit. Contact our billing department if necessary to make prior arrangements. We accept Cash, Checks, Visa, MasterCard, Discover and American Express.

- For minors, payment is expected to be made by the parent/guardian who brings the child to the appointment at the time of service.

- Appointments: We have reserved a specific time for you to see the doctor. We understand that there are circumstances that require you to either cancel or reschedule your appointment. If unable to keep appointment, kindly give 24 hours notice. If you miss an appointment or do not call at least 24 hours in advance to cancel, you will be counted as a **"NO-SHOW**". If you incur **THREE (3) "NO-SHOWs" in the last 12 Months,** your privilege as a patient in our practice will be terminated and you will be dismissed from the practice.

I understand the "no-show" policy and will cancel appointments at least 24 hours in advance.

Signed_____ Date_____

Your signature will be updated annually. If you would like a copy please ask any one of our staff.

Signed_____ Date_____