



Millennium Medical Care Reston
1800 Town Center Dr, #220
Reston, VA
703-440-7000
703-440-7999(Fax)

Patient Name _____ Today's Date: ____/____/____

HIPAA NOTICE

Yes, I have reviewed the copy of Millennium Medical Corp's Patient Privacy Regulations (HIPAA).

Initial here

CANCELLATION, NO-SHOW, & RECORDS POLICY

The following is our policy regarding cancellations and no-shows.

***We require 24 hours' notice in the event of a cancellation

***There is a **\$50.00 charge** for a cancellation without proper notice for weekday appointments and **\$75.00 charge** for weekend appointments. This charge will not be covered by insurance, and will have to be paid by you personally.

When a patient does not show as scheduled, three people are hurt. You, because you don't get the medical treatment you need; the doctor, who now has a space in their schedule since the time was reserved for you; and the other patient, who could have been scheduled for treatment if there had been proper notice.

I, _____ understand that there will be a charge for the release of these records. (\$15.00 for copying plus \$0.50 per page for the first 50 pages, then \$0.25 for the remaining pages)

***Please note that until all account balances including the fee for the release of records are paid, medical records will not be released.

Patient's Signature

_____/_____/_____
Today's Date