Collection of Personal Information – Notice to Reader

The health information that we collect is needed to provide you with diagnostic, treatment and care services or for other authorized purposes under section 27 of the *Health Information Act*. It is collected under the authority of the *Alberta Health Care Insurance Act* and/or section 20(b) of the *Health Information Act* and is directly related and necessary to carry out an authorized purpose as outlined in section 27 of this act. The confidentiality of this health information and your privacy are protected by the provisions of the *Health Information Act*.

If you have any questions about this collection and use of your health information, please talk to one of our staff, or contact our privacy information officer (listed in our *Privacy Protection Policy*) at 403-242-2600.

Responsibility for Payment for Services Rendered

Insured Persons:

Our office is willing to accept direct payment from your INSURANCE PLAN for the cost of services we provide and which your plan covers.

Your particular insurance plan may not cover all of the costs you incur for your treatment. This can occur because the fees in our office are based on specialist fees, whereas your plan may only pay non-specialist rates. Additionally, there may be procedures that may not be covered through your insurance plan at all.

If your plan does not cover the full cost of your treatment you will be responsible for any difference between the amount paid by your plan and the amount charged for your treatment. We will inform you of any balance owing. **You will be responsible for prompt payment of that balance.**

Noninsured Persons:

You are **directly responsible for all costs** incurred at the time services are rendered.

Cancellation on Short Notice

A fee will be charged for each missed surgical appointment if we are not notified within **3 business** days. This fee will be $100 for each ½ hour of missed time and will be cumulative for longer appointments.

If you have any questions, please ask our receptionist. If you understand the contents of this form and agree to have the benefits from your plan for your surgical treatment paid directly to our office and to the ramifications of missed appointments, please sign below.

______________________________ ______________________________

Patient or Guardian Signature Date (mm/dd/yyyy)