



Privacy Practices of The Hand Center

I, _____, have been offered a copy of The Hand Center, P.C.'s Notice of Privacy Practices, and have either ___ been provided with a copy, or ___ do not wish to review a copy of the policies.

Signature: _____ Date: _____

NO SHOW POLICY

A fee of \$75.00 will be charged for a missed appointment. The fee will apply unless The Hand Center, P.C. is notified 24 hours in advance of the stated appointment.

THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE PLAN AND IS THE PATIENT'S RESPONSIBILITY.

I agree to pay a \$75.00 fee for any missed appointments that are not cancelled 24 hours in advance.

Signature: _____

80 Garden Center
Suite 223
Broomfield 80020

4745 Arapahoe Boulevard
Suite 140
Boulder 80303

1606 Prairie Center Parkway
Suite 250
Brighton 80601