Schwieters Medical, PLLC
2781 Pilot Knob Road
Eagan, MN 55121
Phone: (651) 289-7300
Fax: (651)289-7301

If your insurance changes we must be notified at the time of the appointment. If you do not inform us of the change and the insurance claim is denied, you will be responsible for the charge that day.

_____ _____/_____/_____
Printed Name Date of Birth

I hereby authorize payment of medical benefits for services rendered to me and/or my dependents to Schwieters Medical, PLLC from any and all insurances that I and/or my dependents may be covered by at the time of service.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Privacy Policy

The privacy of your medical information is important to us and we are committed to protecting it. A record of your care will be created for the services received while you are a patient at our office. This record is necessary to provide you with quality care and to comply with certain legal requirements. Your medical information may be disclosed to other treating providers at your request, your insurance company to assist in payment of your claim and to pharmacies to assist in obtaining your medications. Full notice of our privacy policy is posted on our waiting room wall and you are being given a copy of this notice. Your signature on this form acknowledges that you have read this policy and have been informed of the privacy policy of this office.

We attempt to send reminder texts or emails for your appointments, but a **24 hour notice** is required from you for cancellation without a possible fee. The number/email we use for these reminders are obtained from you when setting up your intake appointment. **Appointments cancelled without a 24 hour notice may be billed directly to you.** Your signature below acknowledges that you understand you are financially responsible for any charges not covered by the assignment above. A service charge of 1.5% (18% annual rate) or the highest statutory amount allowed, whichever is higher, will be charged on accounts past due 90 days. If payment from insurance is not received within 120 days, the account is due and payable in full. Accounts 6 months past due will be subject to collection procedures and/or small claims court. The client agrees to be held responsible for the cost disbursement, including reasonable attorney, collection and court fees.

_____ _____/_____/_____
Signature of Patient Date

_____ _____/_____/_____
Signature of Responsible Party Date