



****PLEASE PRINT.....PLEASE PRINT*****PLEASE PRINT.....PLEASE PRINT****

Patient Name: _____ Date of Birth: ____/____/____

Choctaw Family Medicine & Aesthetics (CFMA) has implemented policies and procedures so that we may provide the best healthcare available to our patients. CFMA policies and procedures were developed to protect not only CFMA providers and staff, but to protect our patient’s rights as well. CFMA encourages all patients or parents/guardians to read and familiarize their self with the *CFMA Patient Handbook*. Patients are given a *CFMA Patient Handbook* at their first patient appointment. (Families are given one *CFMA Patient Handbook* per family.) Included in the CFMA Patient Handbook are patient copies of the following policies:

- CFMA Notice of Privacy Practices
- CFMA Financial Policy
- CFMA Administrative Policy
- CFMA Medication Policy

By signing below I agree I have been given a *CFMA Patient Handbook*. I have been given the opportunity to read, review and ask questions. I understand my cooperation with the policies listed is necessary for CFMA to provide the best healthcare possible. I understand that listed within these policies are responsibilities I must accept as a patient or parent/guardian of a minor patient. I agree to abide by the policies set forth by CFMA. I understand that violation of one or more of these policies could result in dismissal from CFMA’s practice.

Please ask any CFMA staff member if you have any questions or concerns. Thank you.

Patient or

Parent/Guardian Signature: _____ Date: _____

****PRINT****

Parent/Guardian Name: _____