Patient Account #: _____
(office use only)

Sheridan Medical Group
Office Policies and Procedures for our Patients

Receipt Acknowledgement Form

By initialing the items below, I acknowledge that I have read the New Patient Welcome Packet in its entirety. I have reviewed the main topics listed in the New Patient Packet. I have had the opportunity to ask questions and they have been answered to my satisfaction.

_____ Patient Portal Required

_____ Yearly Annual Visit Required

_____ Office Hours

_____ Same-Day Appointment Availability

_____ Please Call Us First

_____ Cancellations

_____ No-Show Appointments

_____ Insurance, Billing, and Patient Statements

_____ Completion of Forms/Letters

_____ Prescriptions and Refills

_____ Specialty and Other Support Services Available

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures described in the Sheridan Medical Group OFFICE POLICIES & PROCEDURES FOR PATIENTS document.

Patient or Guardian **Signature**: _____

Patient or Guardian **Printed Name**: _____

Relationship to patient (if applicable): _____

Date: _____