

# **NEW HORIZON FAMILY HEALTH SERVICES, INC.**

## **TREATMENT / PAYMENT AGREEMENT FOR NEW HORIZON FAMILY HEALTH SERVICES, INC.**

I request the above to provide me and/or my family with medical care. I acknowledge my responsibility to pay for that care according to the fees established. Furthermore, I authorize assignment of benefits for medical / dental service to be paid to NEW HORIZON FAMILY HEALTH SERVICES, INC.

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Signature

Date

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### **NEW HORIZON FAMILY HEALTH SERVICES, INC. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM**

I \_\_\_\_\_, hereby acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices for New Horizon Family Health Services, Inc. and that I have been given the opportunity to ask questions about this notice.

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Signature

Date