ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this Acknowledgement. I have read and understand about my rights as a patient concerning privacy and the release of my medical information. I know that my records will not be released or shared with anyone without my permission.
If there is anyone you would like any information to be released to, please list at the bottom.

Print name: _____ Sign: _____ Date: _____

Broken Appointment and Cancellation policy

It is our goal to provide quality dental care for you and your family at a reasonable fee. Broken appointments and cancellations result in non-productive times that inevitably increase our fee to you.

There will be a $50 charge for all missed appointments and cancellations less than 24 hours prior to scheduled appointment time. We regret this must be instituted and appreciate your understanding as we continue our efforts to provide quality family dentistry in the most efficient manner.

Policy for Filing Insurance

Our office is not in any network; however, we will file to all insurance companies. You will be responsible for any charges that your insurance does not pay. If any claim is not paid in a reasonable amount of time, we will refile only one time. The balance due will be your responsibility to pay and follow up with your insurance for any reimbursements.

Print name: _____ **Sign:** _____

Date: _____

If at any time your records need to be sent to another dentist, per your request, we will be glad to, as long as this paper is signed and dated.

I give my permission for my dental records to be sent to any dentist of my choice.

Print name: _____ Sign: _____

Date: _____