

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Please Print Name

Relationship

Please Print Name

Relationship

Please Print Name

Relationship

NO SHOW AND CANCELLATION POLICY

A missed appointment prohibits the practice from providing care to patients with true dental needs. A fee of **\$35.00** will be charged to the patient for a **missed or cancelled appointment** if a **48 hour notice is not given**. Depending on the length of your appointment the fee could be up to **\$75.00**.

After a third "no show" the patient will be dismissed from the practice.

Payment for a missed appointment is the responsibility of the patient and is due upon receipt of the charge. Future visits will not be scheduled until the missed appointment fee is paid.

This is a practice policy that is not applicable to any insurance rules or regulations. The sole purpose of this policy is to protect the practice from loss of availability to its patient's dental needs.

Signature of Patient or Guardian

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign Other (Please Specify) _____

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement