ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

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

Per HIPAA Rules you may refuse to sign this HIPAA portion of the acknowledgment form

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

Scheduling and Financial Policies

I have read, understood and accept the terms of the outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Shorey Dentistry. I am fully aware that I am the final responsible party for these commitments. I am also aware that any cancellations or reschedules made within 48 hours of the appointment time will result in a $40 cancellation charge.

_____ _____
(Signature) (Date)

Acknowledgment & Authority

I, _____, Consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance or operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor or other qualified designate. I am also fully aware of the possibility of infections, swelling and paresthesia occurring when any surgical procedures such as extractions of teeth, apical surgery, etc. are involved.

_____ _____
(Signature) (Date)

****For Office Use Only****

We attempted to obtain written Acknowledgment of Receipt of Notice of Privacy Practices, but acknowledgment could not be acquired because:

___ Individual refused to sign
___ Communications barriers prohibited obtaining acknowledgment
___ Other (please specify)