

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* 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

OFFICE POLICIES

Payment is requested at the time services are rendered. Payment terms may be arranged with the receptionist prior to the appointment in the case of extensive treatment.

As a service to me, Family Dental Care will file my insurance forms, but I understand that I am financially responsible for all charges not paid by the insurance company after 60 days following treatment.

Please check the method of payment: ___ Check ___ Cash ___ Visa or MasterCard. In the event that payment is not made within 15 days of receipt of statement, 1.5 % (18% APB) interest plus a service charge may be added to the past due account.

We do try to confirm appointments two days in advance and would appreciate a returned call. If I fail to give 24 hours notice of appointment cancellation, I consent to being billed for that appointment time.

I agree to pay a \$25.00 charge for returned checks.

If collection or legal services are required to obtain payment, I agree to pay for the reasonable costs incurred in connection therewith.