ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
Date

Dental Insurance Information

We will gladly file your insurance claim. Please understand that your insurance contract is an agreement between you, your workplace, and the insurance company, we are not a part of that contract. It is important that you are fully informed about your insurance benefits. We will accept payment from the insurance company, however all fees are ultimately your responsibility.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to the third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or, dentist group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient of parent if minor Date