## 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

### TO OUR DENTAL INSURANCE PATIENTS

We accept assignment of insurance benefits as a courtesy and service to our patients. We will help you receive the full benefits of your insurance coverage, but we can make no guarantee of any estimated coverage. Because the insurance policy is an arrangement between you and your insurance company, we need to emphasize that all patients are financially responsible for the entire account.

Patient _____

### CONSENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. If financial arrangements become necessary, a copy of credit report will be required.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____