Acknowledgement of Privacy Practices

ACKNOWLEDGEMENT FORM

I have received the **"Notice of Privacy Practices"** and have been provided an opportunity to review it.

Patient Name (Print) _____

Patient Date of Birth _____

Parent | Guardian Name if Patient is a Minor (Print) _____

Relationship to Patient _____

Signature _____

Date _____

Missed Appointment and Cancellation Policy

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A $50.00 charge may be assessed for missed, short notice or canceled appointments. Multiple failed appointments may result in being dismissed from the dental clinic.

Please Initial:

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