RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have had the opportunity to read the Children's Dentistry Notice of Privacy Practices and a copy was made available to me.

______________________________________ ______________

Signature – Patient or Personal Representative Date

____

child(ren)'s name(s)

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

____

Patient Name ______________________________________

Patient Date of Birth (DOB)____________________________

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Further, your signature authorizes the release of medical information to your primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of dental benefits to the dentist.

Do we have permission to:

Send a reminder card to your home?	Yes ☐	No ☐
Leave a message on your answering machine at home?	Yes ☐	No ☐
Call/Leave a message at your place of employment?	Yes ☐	No ☐
Discuss your medical condition with any member of your household?	Yes ☐	No ☐

If yes, whom:________________________________ Relationship:____________________

____ ______________

Patient/Responsible Party Signature Date