Missed Appointment(s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best service to our patients, we require at least a 48 hour notice for cancellations or for re-scheduling your appointment. If you give less than 48 hour notice your account will be charge a $75 fee for each appointment slot you are booked for. We understand that unforeseen circumstance may arise, which may result in canceling or missing your appointment. Multiple failed appointments may result in being dismissed from the practice.

Coming Late for Appointments:

We kindly give a 10 minute grace period from your appointment time. If you come any later than 10 minutes it will be considered a broken appointment and your account will be charge a $75 fee (refer to the Missed Appointment(s) and Cancellation Policy above). If we are still able to see you after the 10 minute grace period you will be charge a $35 dollar late fee.

Consent:

I have read understand and agree to the above term and conditions. Authorize my insurance company to pay me dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due before the services are rendered.

Patient/Guardian Print Name | Patient/Guardian Signature | Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2016

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Guardian Print Name | Patient/Guardian Signature | Date

Witness | Position | Date