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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment*

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

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- | | |
|---|---|
| <input type="checkbox"/> Individual refused to sign | <input type="checkbox"/> Communications barriers prohibited obtaining the acknowledgement |
| <input type="checkbox"/> An emergency situation prevented us from obtaining acknowledgement | <input type="checkbox"/> Other (Please Specify) _____ |

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INSURANCE INFORMATION

Insurance typically is paid over the course of treatment. For example, if treatment is estimated to be 2 years, the payments will come periodically over the course of treatment. Change in your insurance policy, for any reason, will affect the amount of the insurance to be received; therefore any changes must be reported to us as soon as possible. Any conflicts that arise with your insurance policy regarding payment benefits will become your responsibility.

In any cases where there is more than one insurance company involved, payments from the secondary company are, in most cases, dependent on what the primary insurance will pay. Please consult your insurance company manual to confirm their policy.

Patient/Guardian Signature: _____ Date: _____

*If not signed by the patient, please indicate your relationship to the patient: _____

APPOINTMENTS

I acknowledge that there may be times where appointments may need to be scheduled during normal school or work hours. These include longer appointments such as (but not limited to): getting braces put on or removed, x-ray and repositioning of brackets, or consultations and re-exams. However, we will try to accommodate your scheduling needs as best as possible.

Signature/Guardian Signature: _____ Date: _____

*If not signed by the patient, please indicate your relationship to the patient: _____