Russell W Fife, DDS
www.drfife.com

Patient Acknowledgement

I understand that my insurance coverage is an agreement between my insurance company and me, and I understand that I am responsible for my financial obligations regardless of my insurance benefits.

I understand that I may be charged a 1.5% per month or $2.00 finance charge if my balance goes beyond 90 days. For returned checks, an NSF fee of $ 25.00 will be applied. In the event of default I am responsible for legal interest collection cost and reasonable attorney fees in an any collection efforts.

I assign dental benefit payments to be paid directly to Dr. Russell Fife unless my account is paid in full at the time of service.

My patient and medical history information is truthful and complete to the best of my knowledge.

I understand that the photographs, slides, study models, x-rays and/or videos will be used as a record of my care, and may be used for educational purposes in study club meetings, lectures, seminars, demonstrations, professional publications (journals, magazines), and Dr. Fife's website. If used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these materials.

Print Patient Name_____

Patient/Guardian Signature _____

Today's Date _____

Russell W. Fife
8100 Lomo Alto Suite 160
Dallas, TX 75225
214-368-0018

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____ have received a copy of
Patient Name

Dr. Russell W. Fife's Notice of Privacy Practices.

_____
Please Print Name

_____
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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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