ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of this office's Notice of Privacy Practices.

You have the right to refuse to sign this acknowledgement.

_____ _____

Print name of patient Date

_____ _____

Signature of patient or patient representative Relationship to patient

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)

_____

_____

_____

FINANCIAL/CANCELLATION POLICY

Payment is expected at time of service. If you have dental insurance, we will be happy to submit your claims for you. We do this as a courtesy to you. Co-payments and deductibles are due at time of service unless prior financial arrangements have been made.

Your appointment has been reserved especially for you. We ask that you kindly give us 48 hours notice if you are unable to keep your appointment to avoid a $50 cancellation fee. We do understand that emergencies arise, please let us know if this is the case.

I have read and understand the above information. I acknowledge that I am responsible for all charges incurred from services rendered by Dr. Alex Sutton.

_____ _____

Print name of patient Date

_____ _____

Signature of patient or patient representative Relationship to patient