DONALD W. WARREN, DDS & DARRYL W. WARREN, DDS, PLLC

IF THIS IS YOUR FIRST VISIT, WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

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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 1st PATIENT NAME:_____ DOB: _____

PRINT 2nd PATIENT NAME:_____ DOB: _____

PRINT 3rd PATIENT NAME:_____ DOB: _____

I GIVE THE OFFICE OF DONALD W. WARREN, DDS & DARRYL W. WARREN, DDS, PLLC PERMISSION TO DISCLOSE MY HEALTH INFORMATION TO THE EXTENT NECESSARY TO HELP WITH MY HEALTHCARE:

TO THESE INDIVIDUALS: _____

_____

I AGREE TO BE RESPONSIBLE FOR ALL CHARGES. IN THE EVENT I DO NOT PAY MY ACCOUNT AS AGREED, I AGREE TO BE RESPONSIBLE FOR ALL COSTS OF COLLECTING MY ACCOUNT SO THE OFFICE OF DONALD W. WARREN, DDS & DARRYL W. WARREN, DDS, PLLC WILL RECEIVE 100% OF THE CHARGES INCURRED, EVEN IF THIS ACCOUNT IS PLACED FOR COLLECTION. I WILL BE RESPONSIBLE FOR THE ORIGINAL AMOUNT PLUS ANY COLLECTION FEE.

PRINT RESPONSIBLE PARTY NAME: _____
(If patient/s under age 18)
RESPONSIBLE PARTY SIGNATURE:_____ DATE: _____

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AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

I agree that the dental practice may communicate with me electronically at the email address below.
I am aware that there is some level or risk that third parties might be able to read unencrypted emails. I can withdraw my consent to electronic communications by calling: (501)745-4656.

Email address (PLEASE PRINT CLEARLY) _____

SIGNATURE: _____ DATE: _____

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DENTAL OR MEDICAL INSURANCE – AUTHORIZATION FOR SIGNATURE ON FILE

I _____ hereby authorize the office of Donald W. Warren & Darryl W. Warren, DDS, PLLC to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents.

_____ I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Donald W. Warren, DDS & Darryl W. Warren, DDS, PLLC, if applicable.

I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental or medical services and materials. To the extent permitted under applicable law, I authorize release of any information relating to the claims.

SIGNATURE: _____ DATE: _____