LEVERETT FAMILY DENTISTRY

Patient Name:_____ Date of Birth:_____Phone number:_____

24 Hour Cancellation Policy

I understand that this office has a **24 hour Cancellation Policy** and I reserve the right to cancel my scheduled appointment up to 24 hours before; failure to do so will result in a **$25 office fee** on the **first offense** and we reserve right to **dismiss the above-named** recipient/patient **on second offense** if we choose to do so.

Signature:_____Date:_____

Patient Acknowledgement & Consent of Privacy Practices

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy upon request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient): _____

Patient Authorization

I hereby authorize: Leverett Family Dentistry (Name of individual(s) and/or organization providing information)

I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for purposes beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

Signature:_____ Date:_____

Patient Financial Agreement

Payment is due when services are rendered. I understand that this practice reserves the right to turn my account over to a collection agency if account balance has not been settled within 90 days of procedure.

Signature:_____ Date:_____