

Acknowledgement of Receipt

I acknowledge that I received a copy of Dexter Dental Center's Notice of Privacy Practices. I also understand payment is due in full at the time of treatment unless prior arrangements have been approved.

This office accepts insurance so I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I UNDERSTAND THAT DEXTER DENTAL HAS A 24 HOUR CANCELLATION POLICY. IF AN APPOINTMENT IS CHANGED OR CANCELLED WITHOUT 24 HOURS NOTICE THERE WILL BE A FEE INCURRED.

Signature

Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, The CDC and the ADA.