SF

SF Dental House

Patient Acknowledgment of Receipt of
Notice of Privacy Practice and
Financial Responsibility

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will insure that your information remains private.

Please list all telephone numbers where we may contact you:

1._____ 2._____ 3._____ 4._____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, GRANDPARENTS, ETC...) YOU AUTHORIZE US TO RELEASE YOUR HEALTH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Acknowledgment of Notice of Privacy Practice and Financial Responsibility

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice and understand that the practice will offer me an updated copy to the Notice should it be amended, modified, or changed in any way upon my request.

I further acknowledge and agree that all accounts past 30 days shall bear a compounding interest of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services rendered, West Lovers Dental may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees, and court cost incurred in the collection of my overdue account.

Effective October 1, 2015 - appointment cancellations must be done more than 24 hours before scheduled appointment. If the cancellation is made within 24 hours of your scheduled appointment, a cancellation fee in the amount of $25.00 will be automatically charged to your account (may not be billed to insurance).

Print Patient Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

Office use only

Patient refused to sign because:_____

Date:_____ Signature: _____