Adams Dental Group

Acknowledgement of receipt of Notice of Privacy Practices

I________________________ have received a copy of Adams Dental Group's Notice of Privacy Practice.
(*please print name*)

Signed: X______________________________________ Dated:______________

Signature of patient-or- parent if patient is a minor

The following person (s) has my permission to share in my personal health information:

Name :_________________________________ Name:______________________________

*******Adams Dental Group Scheduling Policies******

Please note: As a patient, I am responsible for understanding my insurance policy and its applicable dental benefits. I agree that payments/co-shares are due on the date that services are provided and that all Insurance estimates are only estimates and not a guarantee of payment by my insurance company.

Patient Initials: _________

Cancellation Policy: Kindly give 24-hour notice, not including weekends, when rescheduling or cancelling your dental appointment. Same day cancellations may result in a $25.00 failed appointment fee.

Patient initials: ________