

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

{PLEASE PRINT NAME}

{SIGNATURE}

{DATE}

CANCELLATION AND MISSED APPOINTMENT FEE POLICY

I UNDERSTAND THAT DR. BOYD, P.C. WILL MAKE A CHARGE FOR APPOINTMENTS THAT ARE MISSED OR ARE CANCELLED WITHOUT APPROPRIATE NOTICE. I AGREE TO KEEP MY SCHEDULED APPOINTMENTS AND IF NECESSARY PROVIDE A MINIMUM OF 1 BUSINESS DAYS' NOTICE WHEN I CANNOT KEEP TO THE RESERVED TIME. I AGREE TO PAY THE FEE INCURRED IF I MISS AN APPOINTMENT OR CANCEL WITHOUT A MINIMUM OF 1 BUSINESS DAYS' NOTICE. THE FEE FOR THE DENTAL HYGIENIST IS \$150. THE MINIMUM FEE FOR A DOCTOR SCHEDULED APPOINTMENT IS \$250 PER HOUR.

SIGNATURE

DATE

PERMISSION TO DISCUSS TREATMENT WITH A THIRD PARTY

I, _____ AUTHORIZE DR. BOYD, P.C. TO DISCUSS MY DENTAL HEALTH CARE NEEDS INCLUDING
{PLEASE PRINT NAME}

PAYMENT AND DENTAL INSURANCE WITH _____

{NAME & RELATIONSHIP TO PATIENT}

I UNDERSTAND THAT I HAVE THAT RIGHT TO REVOKE THIS PERMISSION IN WRITING AT ANY TIME AND THAT DR. BOYD, P.C HAVE 30 DAYS TO COMPLY WITH MY WRITTEN NOTICE.

{SIGNATURE}

{DATE}

FOR OFFICE USE ONLY

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

- INDIVIDUAL REFUSED TO SIGN
- COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
- AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
- OTHER (PLEASE SPECIFY) _____