WASHTENAW DENTAL ASSOCIATES

Patient Acknowledgment and Consent Form

PATIENT ACKNOWLEDGMENT OF HIPPA:

I acknowledge that I have today received a copy of the Notice of Privacy Practice.

PATIENT CONSENT:

I consent to your disclosures of my information, which you deem are necessary in connection with the treatment (i.e. Referral/consult with a specialist or other health care provider). I understand that such disclosures may not be of the type listed above.

PERMISSION FOR PATIENT INFORMATION:

I give permission to release treatment and financial information to the person(s) named below concerning my account.

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TO AVOID RESCHEDULING CHARGES……..

Without a 48-hour notification of cancellation, there will be a $35 charge per 30-minute appointment.

FINANCIAL ARRANGEMENTS . . .

Payment is due at time of service.

If you have insurance coverage, you are responsible for keeping track of your insurance maximums, deductibles, percent of coverage, etc. and of notifying us of any changes**. Anything that your insurance company does not cover becomes your responsibility**.

______________________________ ______________________

Signature Date