PATIENT ACKNOWLEDGEMENT of RECEIPT

Patient Treatment Consent:

- I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.
- I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorizes Angel Dental Care to submit insurance claim forms and receive payment directly from my insurance carrier with the notation "Signature on File". I authorize my Dentist(s) to release treatment records, x-rays and any other information deemed pertinent to my insurance carrier as necessary or requested.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that any claims the carrier does not pay or any balance that extends beyond 60 days from the date of treatment may be assessed a service charge of 5% per month.

We strive to give each patient a courtesy call one to two days in advance of your scheduled dental visit. However, you are expected to keep your appointment time with or without the courtesy call. Therefore we ask your consideration and that you kindly give 48-hour notice if you are unable to keep your appointment. Please note that if 48-hour notice is not given, there may be a $60 per half hour for a broken appointment fee. A broken appointment is a loss to yourself, your dentist and his team members, and to another patient who could have had that appointment time. We reserve the right to terminate your relationship with our office after repeated broken appointments without 48-hour notice.

_____ _____

Patient Name Patient or Responsible Party Signature Date

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Medical History Update:

I have filled out my medical history update information and it is true to the best of my knowledge.

_____ _____

Patient Name Patient or Responsible Party Signature Date

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Patient Business Policy:

I have received Angel Dental Care's Patient Business Policy and Oral Hygiene Packet. I have read, understand and agree to the provisions of the said policy. I understand that by declining to sign, I will not be treated at Angel Dental Care.

_____ _____

Patient Name Patient or Responsible Party Signature Date

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Privacy Policy:

I have received a copy of the Notice of Privacy Practices.

_____ _____

Patient Name Patient or Responsible Party 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 acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other _____