Dentistry by Design

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)

Appointment Reminder Form

Because we understand that life can be extremely busy, we would like to ensure that you are always reminded of your appointments. Please provide us with the following information.

Home Number: ( ) _____
Cell Number: ( ) _____
Work Number: ( ) _____
Emergency Contact: ( ) _____

Email Address:_____

Does our office have permission to: (please circle)

Leave a message on your answering machine at home?	Yes or No
If you listed a cell phone number above, may we contact you at this number?	Yes or No
Leave a message or try to contact you at your place of employment?	Yes or No
Discuss your dental condition with a member of your household?	Yes or No

If yes, whom: _____ Relationship: _____

INSURANCE: I understand that the portion of my treatment not covered by insurance is due and payable at each visit. I also understand that my insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the doctor, and that I am still responsible for all fees. If my insurance company has not paid their portion within 60 days of being properly billed, I understand that the balance will become due and payable from me.

RELEASE:

* I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for Proper dental care.
* I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
* I authorize release of any information concerning my health care, advice and treatment to another dental provider.
* I understand that I am responsible for all costs of dental treatment.
* If I fail to pay for dental treatment, I understand that I am responsible for all reasonable collection Cost including legal fees, court costs and collection agency fees.
* I hereby authorize payment of insurance benefits directly to Richard L. Robinette DMD, otherwise payable to me.
* I attest to the accuracy of the information on this page.

Signature: _____ Date: _____