



sorenson

PEDIATRIC DENTISTRY™

Patient Acknowledgment of Receipt of
Notice of Privacy Practice and
Financial Responsibility

The Health Insurance Portability and Accountability Act, HIPAA, requires that effective April 14, 2003, patient be given a copy of Notice of Privacy Practices.

“I acknowledge, I have received from this office, a copy of the Notice of Privacy Practices.”

“I further acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services rendered, Sorenson Pediatric Dentistry may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees and court cost incurred in the collection of my overdue account.”

Appointment cancellations must be done more than 24 hours before scheduled appointment. If the cancellation is made within 24 hours of your scheduled appointment, a cancellation fee in the amount of \$25.00 will be automatically charged to your account per appointment. Initials: _____

Print Patient Name

Date

Responsible Party

I, _____ authorize Sorenson Pediatric Dentistry to send me text messages notifications regarding appointments.