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.

"I acknowledge and agree to all items noted above."

_____

Print Patient Name Date

_____

Responsible Party Signature

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