Kohlers Crossing Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this Acknowledgment****

I, _____, have received a copy of Dr. Paulette Sanford's Notice of Privacy Practices.

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other (Please Specify) _____

AUTHORIZATION FOR SIGNATURE ON FILE

I, _____, hereby authorize Kohlers Crossing Dental to affix my name to any and all claims or documents as related to any and all health benefits due to me or my dependents. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information related to this claim.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Kohlers Crossing Dental. This "Signature on File" will be valid from this date forward. A photocopy of this document may act as the original.

_____
Signature of Patient or Legal Representative

_____ _____
Printed name of Patient or Legal Representative Date