*Family Smile Dental*
3029 Avenue V
Brooklyn, NY 11229
Tel (718) 332-4060
Fax (718) 676-0228

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# 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:**

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**For Office Use Only**

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

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

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**FOR INDIVIDUALS WITH DENTAL INSURANCE: PLEASE READ THE STATEMENT BELOW**

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company for reimbursing the cost of dental services. It is not a contract between the dentist and the insurance company.

I understand that I am financially responsible for all services rendered by the dentist. I understand any co-payments, deductibles, and/or procedure cost not covered or denied by my insurance company (including coverage termination prior to the date services are rendered), are my responsibility. This dental office is authorized to fill out and/or assist me to complete any and all insurance forms pertaining to services rendered.

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**Patient Signature: (or Parent/Guardian signature for patient under 18 years of age)** **Date:**

| **AUTHORIZATIONS** |
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| 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.<br>X _____<br>Patient/Guardian Signature Date |
| 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.<br>X _____<br>Subscriber Signature Date |