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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

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\* You May Refuse to Sign This Acknowledgement

I, \_\_\_\_\_ have received a copy of this office's notice  
of Privacy Practices.

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Please Print Name

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Signature

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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 be obtained because:

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

Patient Name \_\_\_\_\_ Relation to Insured \_\_\_\_\_  
Insured Name \_\_\_\_\_ Insured ID/SS \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_  
Dental Insurance Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Group # \_\_\_\_\_

### CONSENT

I authorize Paula Coffee, D.D.S, and Theresa Coffee, R.D.H, after thorough explanation, to take radiographs, study models, photographs and/or any other diagnostic aids deemed appropriate, and perform treatment, medication, and therapy that may be indicated in connection with my (or my child's) dental care. **I also understand that the use of anesthetic agents embodies a certain risk.**

\_\_\_\_\_  
Signature of Responsible Party

### AGREEMENT TO PAY FOR TREATMENT

I understand that I am responsible for payment for all dental services provided in this office (whether or not insurance/third party payer is involved) and that payment is due at the time services are rendered. If I do not pay the entire balance, or if insurance is unpaid after 60 days, a billing charge, or interest will be added to my account. The billing charge will accrue at the rate of 1.5% per month (or a minimum charge of \$2.00), which is an annual percentage rate of 18%. In case of default of payment, I agree to pay any and all costs in collecting this account, including but not limited to reasonable attorneys fees and court costs. I also understand the office policy is to require a minimum of one business day's notice for all cancelled/re-scheduled appointments. If this is not possible, I understand that a fee of \$50 that is not reimbursable by insurance will be charged to my account.

\_\_\_\_\_  
Signature of Responsible Party

### INSURANCE

As a courtesy to our patients, we will prepare and submit your insurance forms for reimbursement. We cannot obtain payment however, unless you provide us with all of the necessary information as requested above. Additionally, please understand that your insurance is a contract between you/your employer and the insurance company. We cannot in any way guarantee benefits or payment from your carrier, nor can we know the specifics of every individual plan. We recommend that you be familiar with the contract plan and limitations associated with you insurance.

Please read and understand that by signing, you are agreeing to the following:

- I authorize my insurance to pay the doctor directly, all insurance benefits otherwise payable to me
- I authorize the doctor to release any information including, but not limited to, records of treatment or examination, personal identification, x-rays, medical history, etc.
- Any estimates given with regards to treatment fees are simply rough guesses based on the limited information we have available about your plan

\_\_\_\_\_  
Signature of Responsible Party