ROGERS CENTER FOR DENTISTRY
PAUL H. ROGERS, DDS

Acknowledgment 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.

_____	_____	_____
(Print Patient Name)	(Patient/Guardian Signature)	(Date)

For Office Use Only

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
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgment
- ○ Other (Please Specify) _____

Appointment and Cancellation Policies

Appointments: We make every effort to create a schedule that provides a timely experience for our patients. If we are significantly delayed, we will attempt to notify you beforehand so you may choose to come later or reschedule. If you are running late, we appreciate it if you notify our office. Late arrivals will be worked into the schedule as time allows. If you are significantly delayed, your treatment may be modified or you may need to reschedule for another day.

Cancellations: We kindly ask for at least 48-hour notice if you cannot make your scheduled appointment. This allows us to make the appointment available to another patient. **I understand there is a $40 fee for missed appointments when 48-hour notice is not provided.**

_____	_____	_____
(Print Patient Name)	(Patient/Guardian Signature)	(Date)

Credit and Finance Charge Policy and Agreement

1. Payment is due at time of service. I am responsible for all costs incurred in my (or my dependent's) care. Financing arrangements may be made in advance if I notify the office manager of Rogers Center For Dentistry (RCFD).

2. Insurance claims. If RCFD submits dental claims on my behalf (or on behalf of my dependent) to an insurance company, I hereby authorize any benefits due me to be paid directly to RCFD (assignment of benefits). Where insurance benefits apply, RCFD will provide me with an estimate of my patient portion, which is expected at the time of service or as arranged in advance. However, RCFD cannot guarantee the exact amount your insurance carrier will pay. **I understand and agree that I am responsible for any co-payments and deductibles, as well as any non-covered service amounts such as those deemed "unnecessary" or "cosmetic" by my insurance carrier. I understand that any balance on my (or my dependent's) account following an insurance payment will be immediately due.** Any overpayment will be credited to your account or reimbursed.

3. Collection Costs. If any unpaid balance is referred to a collections agency, I agree to pay the remaining balance plus all collection costs and fees, including legal fees.

4. Returned Checks. I agree that I am responsible for any and all bank charges on returned checks.

_____	_____	_____
(Print Patient Name)	(Patient/Guardian Signature)	(Date)

Revised 9.19.2016