

DR. CHARLES SAMBORSKI
GENERAL & IMPLANT DENTISTRY

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

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 the acknowledgement
- Other (Please Specify) _____

ACKNOWLEDGEMENT OF OFFICE POLICIES

- 1: Insurance is an agreement between you and your insurance company, ultimately you are responsible to know your benefits and are responsible for payment to our office.
- 2: I assign dental benefits to be paid directly to this office.
- 3: I understand that I will incur a \$15 billing charge for accounts 30 days past due & each month thereafter.
- 4: I give Dr Samborski permission to render treatment we have discussed.
- 5: I understand Office Policy: There is a charge for Broken or Failed appointment without a 48 hour notice.

Signed: _____ Date: _____