Brooks Stevens D.D.S.
FORT WORTH'S FINEST GENERAL 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 Date

_____

Signature

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 acknowledgement

_____ Other, (Please specify)

_____

_____

_____

_____

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OFFICE POLICIES

Our office is committed to providing you with the best care possible. To achieve this goal we need your assistance and understanding of several important office policies.

Commitment to Treatment

We believe that treatment started should be completed. Incomplete treatment leads to complications, misunderstanding, loss of teeth, and further disease. Therefore, this policy states that if you begin any part of your treatment, that part should be completed.

Commitment to Appointment

We reserve a special time for each patient in our practice, and we rarely keep our patients waiting. An appointment is a bond of trust that we will be here to serve you and you will be present for treatment. Our office hours are Monday thru Thursday, 8:30-5:30 P.M. and 7:00-1:00 on Fridays. Your signature below indicates that we must have mutual respect for each other's time.

Commitment to Financial Arrangements

We believe we have a responsibility to use the best professional care, skill, and judgment in providing your dental care. Fees for services are due at the time of treatment. We accept cash, checks, credit cards, and Care Credit. If you have dental insurance, we are eager to help you receive your maximum allowable benefits, and we will be happy to file the necessary claims. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. In most instances we will accept assignment of benefits with your estimated deductible and co-payment due at the time of service. We wish to emphasize again, that these co-payments are estimated because we have no control over your insurance carrier. By signing below, you indicate that you agree to fulfill your financial commitment to our office promptly and completely.

I have read this form and agree to all of the above commitments. If applicable, I authorize payment of insurance benefits directly to the provider, and I authorize the release of all necessary information to the insurance carrier and their representatives.

_____ _____

Signature Date