Notice of Privacy Practices
Acknowledgement of Receipt

I acknowledge that I received a copy of Dr. J. Andres Rodriguez DMD and Associate's Notice of Privacy Policies and Practices.

Patient Name:_____

Signature:_____ **DATE:**_____

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental or medical needs.
2. Upon such diagnosis, I authorize to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the events payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (!*% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient Signature_____ **DATE:**_____ **WITNESS**_____

Patient/Responsible Party's Signature_____ **Relationship to Patient**_____

Acknowledgement form

(One form per family)

Name: _____

Current Address:

_____

_____

_____

Current Telephone Numbers:

Cell: _____

Home: _____

Work: _____

Email: _____

Best time to call? _____

Best number to call? ☐**Cell** ☐**Home** ☐**Work**

Appointment preferences:

Days and Times _____

We provide you with a courtesy appointment reminder service through monthly post cards, 48 and 24 hours calls and possibly an email remainder (soon we may give you the availability to verify your appointments online) which is why are updating our e-mail listings to better serve you. If you wish to not have reminders sent electronically please indicate so next to your email address.

We charge $50 dollars per scheduled hour for missed appointments or short notice cancellations. If you have a Credit Card on file already this may be used for charges on co-payments and other fees as disclosed before procedures or incurred at the time of treatment, cancellation fees are due immediately and will be notified to you at the moment of appointment failure. Written notification of the charges will be included with your receipt and current account information. We do not accept American Express, Dinners Club, Discover or Capital One cards. You may assign a checking account number or a debit card at no extra charge. Fees for missing appointments are not covered by your insurance carrier.

Card Type: ☐Visa ☐**Master Card** ☐**Care Credit**

Card Number: _____

Expiration Date: _____

Circle One: **Credit or Debit**

OR:

Checking account number: _____

Bank Routing Number: _____

Name of Bank: _____

Signature: _____ **Date:** _____