Robert C. Scheele D. D. S.

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 acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Robert C. Scheele, D.D.S.

Release of Medical Information to Family Members

I authorize Robert C. Scheele, D.D.S. to discuss and release all medical information to family members named below, including medical records, x-rays, history, findings, and prognosis pertaining to the medical condition, services rendered, or treatment given to me.

Name _____ Relationship _____

Name _____ Relationship _____

Your Signature _____ Date _____

PATIENT NAME: _____
(Please print patient name)

Authorization and Consent

I certify that I have read and understand the Medical Questionnaire and any questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any treatment or exam records for me or my child to third party payors or health practitioners. I authorize any insurance company directly to pay to the dentist. I also understand that the use of anesthetic and analgesic agents embodies certain risks including permanent numbness of lips and tongue, and dental treatments are not guaranteed to always be successful. I authorize the Doctor to perform any and all forms or treatments, medication and therapy that may be indicated in connection with me or my dependent.

I understand that my dental carrier may pay less than the actual bill for services and agree to be responsible for payment of all services rendered on me or my dependents behalf. PAYMENT IS DUE ON DAY OF SERVICE.

I understand credit bureau reports may be obtained. In the event of default, I promise to pay legal interest on the indebtedness together with collection costs and reasonable attorney's fees as may be required to collect.

X_____Signature of patient (or parent if minor)
_____Date