ROGUE VALLEY
FAMILY DENTISTRY

Acknowledgement of Receipt of Privacy Practices

By completing and signing below you acknowledge receipt of our Notice of Privacy Practices

Printed Name:_____

Signature: _____ Date:_____

****You May Refuse to Sign This Acknowledgement****

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)

Responsible Party

Authorization and Release: I authorize Rogue Valley Family Dentistry (RVFD) to release any information regarding the examination or treatment rendered to my child or me to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to RVFD any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependants.

Collection Fee Policy: If it is necessary to refer this account for collection buyer agrees to pay seller reasonable attorney's fees and collection costs including any collection fees charged by a collection agency, even though no suit or action is filed. If a suit or an action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action including any appeal therein, is tried, heard, or decided. A finance charge of 9% annual interest will be charged monthly on any account balance that is past due 90 days or more.

Signature:_____ Date: _____

Optional Authorization to Release Information

If you would like us to be able to talk to another person regarding your treatment, treatment planning, or financial obligations complete this section. By completing and signing the statement below, I authorize Rogue Valley Family Dentistry to release my Protected Health Information (PHI) to the person(s) indicated.

I, (your printed name) _____, authorize the following person(s) to have access to my Protected Health Information.

_____ _____

Persons Printed Name Relationship to you

_____ _____

Persons Printed Name Relationship to you

Signature: _____ Date:_____