Patient Authorization

Initials

Notice of Privacy Practice Patient Acknowledgement

____ I have received and understand this practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practice upon request.

Appointment Policy

____ At our patient's request, we have adopted office appointment guidelines that allow our patients to pre-reserve and schedule convenient appointment times. Our practice is dedicated to your quality care and is pleased to reserve this time for you. In return, we ask that patients make every effort not to change reserved dental appointments. Broken & missed appointments create scheduling problems for other patients as well as the practice.

In order to accomplish this we have developed the following office policies:

We strive to confirm your appointment at least 48 hrs in advance; however, this service is a courtesy to you. It is ultimately your responsibility to confirm your appointment at least 24 business hrs in advance.

You can confirm your appointment by calling and speaking with a staff member or leaving a message on the answering machine one business day prior to your reserved appointment.

If a call is not received 24 hrs before the appointment reservation our office reserves the right to schedule other patients into your reserved time. The Doctor reserves the right to charge for excessive missed appointments.

Appointments failed without adequate notice will be rescheduled at the doctor's discretion. Multiple broken appointments (2 or more) will result immediate discontinuation of treatment and dismissal from the practice.

Insurance Assignment

____ I irrevocably assign and transfer to Franklin Dentistry Associates, P.A. all insurance benefits covering the offices services for the payment of services rendered. I understand it is my responsibility to comply with all pre-authorization requirements and that I am responsible for any amount insurance will not cover and all deductibles.

_____	_____	_____
Signature of Patient or Representative	Relationship to Patient	Date
_____		_____
Witness		Date