MGODENTAL.COM
Family and Cosmetic Dentistry

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Patient Acknowledgement of Receipt of Dental Material Fact Sheet and Notice of Privacy Practice

Effective January 1, 2002, dentist are required by the State of California to provide a copy of the *Dental Martial Fact Sheet* to any patient who will be receiving restorative treatment. This confirmation of the receipt form must be signed by the patient or the patient's guardian and file in the patient's chart, acknowledging receipt of the fact sheet. It is not an informed consent document, and the State of California does not endorse the information nor does it recommend a particular course of treatment; this matter that remains to be discussed between the patient and their dentist. The information contained on the fact sheet is simply intended to educate patients on the various types of materials used by the dentist during the course of restorative dental treatment; in a similar manner to package labeling found on most foods.

In addition, as of April 14, 2003 the Health Insurance Portability and Accountability Act (HIPAA) requires that patients be given a copy of our Notice of Privacy Practice.

I_____, acknowledge I have received a copy of the following from this office.

x_____ 1. Dental Material Fact Sheet.
Initial

x_____ 2. Notice Of Privacy Practice.
Initial

X _____ **X** _____

Patient or Guardian Signature **Date**

If signed by a Personal Representative of the patient, describe the representative's authority to act for the patient.

Office Policy

Please initial

X_____**1.Missed/Cancel appointments**: A missed appointment or late cancelation fee of $25.00 will be assessed for any notice less than 24 hours. Please understand that the doctor reserved time for you. By notifying us in advance this will allow us to schedule patients that need to be seen.
X_____**2. Insured Patients:** Patients who carry dental insurance understand that all charges for dental services that are rendered are the patient /guardian responsibility. As a courtesy, we will file claims to your insurance and allow 30 days for insurance payment. On the day of service we will collect the patient's estimated portion for serviced rendered. You will be responsible for any balance not paid by your insurance.
X_____**3. Record/ X-rays Duplication**: There will be a $25 fee for x-rays/record duplication. Payment is due prior to duplicating; records will then be prepared and ready in 7 to 10 business days.
X_____4**. Updated Information:** It is the patient responsibility to provide the office with any changes in their Health History and or contact information.

I the undersigned, certify that I have read, understand and agree to abide by the above policies.

X _____ **X** _____

Patient or Guardian Signature **Date**