IMPORTANT (please complete this side)

*****Who can we thank for referring you ? _____

PAYMENT IS DUE AT TIME OF APPOINTMENT , UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate and to the best of my knowledge.

I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I acknowledge that the office charges for no-show appointments ($75.00 to $100)

Signature _____ Date _____

SHREWSBURY ORTHODONTICS

Acknowledgement of receipt of notice of privacy practices

I, _____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES .

Name (please print) _____

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 : (Circle one)

- Individual refused to sign
- Communications barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other _____