Please initial the following:

_____ I understand that if I fail to make my appointment or give 24 hours' notice of appointment change, I can be subjected to a fee of $25 for **EACH** hour I am scheduled.

_____ I understand that if my insurance has not responded to a claim within 30 days, I need to follow up or I will be responsible for the balance.

_____ I understand that any unpaid balance over 30 days may be subjected to collection fees not to exceed 30%.

_____ I understand returned checks are subject to a $35 fee as well as county attorney fees.

HIPAA

_____ _____

Name of Patient (please print) Date of Birth

Acknowledgement of Notice of Privacy Practices

------ (A copy of this can be obtained at the front desk) ------

I hereby acknowledge that I have been offered & or received Bluegrass Endodontic Notice of Privacy Practices

_____ _____

Signature of Patient or Guardian Date

Please list anyone else who may obtain any of your records:

Name: _____ DOB:_____ Relation:_____