Authorization and Acknowledgement Form

You May Refuse to Sign This Acknowledgement

Patient's Name: ______________________________

By signing this form, I, ______________________________, understand this office's
(Please Print Name)
insurance, appointment, and payment policies. I also verify that I have been offered a copy of the **Notice Of Privacy Practices.**
I grant permission to notify and leave a message at my home, work, or any other number I provided to discuss matters related to the patient or when confirming appointments.
This form can only be changed in person before any treatment.

I also give consent for the following person(s) to accompany my child to future visits, make appointments, and receive dental information regarding the patient:
Please provide the name and relationship of the authorized person(s).

NAME	RELATIONSHIP	PHONE NUMBER

______________________________ ______________________________
(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:

_________ Individual refused to sign

_________ Communications barriers prohibited obtaining the acknowledgement

_________ An emergency situation prevented us from obtaining acknowledgement

_________ Other (Please Specify)

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