Family Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________, acknowledge that I have been provided a copy of Beautiful Smiles Notice of Privacy Practices, which describes how my health information may be used and disclosed.

____ _____________________

Signature of Patient/Patient's Guardian Date

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Print Name

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Relationship to Patient (If not signed by the patient)

Names of other individuals that I hereby authorize Beautiful smiles to disclose private in-formation to on my behalf i.e. account information, treatment, appointments, etc.

Name:_____________________________________ Relationship:___________________

Name:_____________________________________ Relationship:___________________

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Signature of Patient/Patient's Guardian

AUTHORIZATION FOR SIGNATURE ON FILE

I, ________________________, hereby authorize Beautiful Smiles to affix my name to any and all claims or documents as related to any and all health benefits due to me or my de-pendants and authorize payment of insurance benefits directly to Beautiful Smiles, other-wise payable to me. I agree to be responsible for all charges for dental services not paid for by my insurance carrier or dental benefits payer. To the extent permitted under applicable law, I authorize release of any information related to this claim. This "Signature on File" will be valid from this date forward.

_________________________ _____________________________ _____________

Print Name Signature Date