

Melissa A. Jarrell, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
Office's Notice of Privacy Practices.

Please Print Name _____

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)

PERMISSION TO PROVIDE DENTAL TREATMENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

By signing below, I give permission to Dr. Jarrell and her staff to provide treatment to the above named patient. I accept full financial responsibility for the treatment performed by this office. Insurance forms will be completed as a convenience to the patient; however, payment to the doctor is expected at the time services are rendered. A **service charge** of 1.5% per month (**annual percentage rate 18%**) will be added to all past due accounts. Any account over 30 days past due is subject to a minimum service charge of \$10.00 per month. Should the services of an outside agency be required for collection of this account, I agree to pay reasonable attorney's fees, court costs, and other costs of collection. I authorize you to check my credit from any and all sources.

SIGNATURE

RELATIONSHIP TO PATIENT, IF MINOR

DATE