DENTAL loft AT THE GREENE

Notice of Privacy Practices
Patient Acknowledgment

Patient Name: _____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

The practice reserves that right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by a personal representative of patient):
_____

DENTAL loft AT THE GREENE

Cancellation Policy

Appointment cancellation policy:

We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time is reserved exclusively for you. We reserve the right to charge patients who do not reschedule with adequate notice, or who fail to keep their scheduled appointments.

How to cancel your appointment:

In order to respect the needs of all Dental Loft patients, it is necessary to cancel your appointment, we require that you contact our office 48 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care. To cancel an appointment, please call (937)912-0101 to talk to a member of office staff.

Fees associated with a cancelled appointment:

Failure to cancel an appointment in the required time frame or failure to be present at time of scheduled appointment will result in a $50 fee per hour of reserved time. Exceptions to this policy must be approved by the office manager.

By signing below, I certify that I have read and understand the terms and conditions of the Dental Loft cancellation policy.

Patient Signature/Printed Name:

_____

_____

Date:_____