Pittstown Smiles Family Dental Care

ACKNOWLEDGEMENT OF
Notice of Privacy Practices
Consent to Release of Information
Consent to Assignment of Benefits
Consent to Financial Responsibility

YOU MAY REFUSE TO SIGN THE ACKNOWLEDGEMENT

1, _____ have received a copy of this Offices' Notice of Privacy Practices.

(Initial) _____ I acknowledge that my co-pay and deductible are due and will be collected by the office on the day of service as per my Insurance contract.

_____
Print Name

_____
Signature

_____
Date

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