Gregg C. Hendrickson, DDS & Associates
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Henderson, NV 89052
(702) 735-3284

Notice of Privacy Practices
Patient Acknowledgement

Patient Name:_____
Please Print

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, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice Privacy Practice on request.

Signature:_____

Date:_____

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

_____

CANCELLATION POLICY

I understand that the office requires that I give sufficient notice when canceling a scheduled appointment (**At least 48 hours**).

If sufficient notice is not given, I understand that I will be charged a **cancellation fee of at least $50.**

_____ _____
Signature Date

INSURANCE COVERAGE

I understand that insurance coverage on my dental services before treatment(s) are only **Estimates**.

In many cases, **actual insurance payments are lower** than the estimates given by your insurance company.

_____
Signature Date