

Monticello Dental
CANCELLATION POLICY

Due to the large number of last minute cancellations with our office, we now have a cancellation policy in effect as of June 20, 2003. Anyone who cancels an appointment less than 24 hours in advance of the appointment, or fails to show altogether for an appointment, will be charged **\$25**. There will be no exceptions to this policy.

We certainly understand that things come up and that patients need to reschedule. We only ask that you understand that there are many emergency patients to be seen and calling in advance to reschedule will help us schedule emergency patients sooner.

Printed Name

Date

Signature

MONTICELLO DENTAL

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES & CONSENT FOR
USE & DISCLOSURE OF HEALTH INFORMATION**

You may refuse to sign this acknowledgement

_____ I have read a copy of this office's Notice of Privacy Practices.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Tammy Dejtiranukul
Telephone: 636-300-4280

Fax: 636-300-4290
E-mail: numpoldejti@hotmail.com
Address: 4122 Keaton Crossing Blvd., Suite 101, O'Fallon, MO 63368

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

**If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patient's Name: _____

Personal Representative's Name: _____

Relationship to Patient: _____