ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, ____ have reviewed/received and am aware of Cedar Creek Dental's Privacy Practices and am responsible for updating the office on changes I may have had with my personal information.

Signature ____Date ___________________

DISCLOSURE AUTHORIZATION

I allow you to give Clinical and Financial Information to or answer questions from:

Spouse ____

Parent(s) ____

Child ____

Other (Specify) ____

Signature _______________________________________ Date _____________________________

NO-SHOW POLICY

I am aware of the office's No-Show Policy and agree to the authorization of future charges on my credit/debit card on file to be charged as necessary after my second or more missed/cancelled appointment.

Signature ____ Date ___________________________

(Copy Debit/Credit Card on the back of this form)