Acknowledgement
Receipt of Privacy Practices
Photo Consent
Financial Responsibility

I acknowledge that I have read and received a copy of Majestic Dental Notice of Privacy Practices.

I give Majestic Dental permission to disclose my protected health information to the following individuals involved in my health care and/or payment for health care goods and services

Spouse/Parent ____

Children____

Other____

I give Majestic Dental permission to contact me at the following email address, regarding my dental treatment or any other healthcare information.

Email address____

Authorization for Photo Consent

☐ I consent to have my Photo taken for identification purposes.

Signature of Patient/Guardian____

☐ I decline to have my Photo taken.

Signature of Patient/Guardian____

Authorizations: I have read and agree to the terms and conditions and hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. I understand I am financially responsible to Majestic Dental for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to the cost of collection and/or court costs and reasonable fees should this be required.

Printed Name of Patient____

Signature of Patient/Guardian_____________________________________ Date___________________