HEBRON DENTAL CARE
124 N. 5th P. O. Box 76
HEBRON, NE 68370

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign the Acknowledgement

I,____, have received
(Please Print Patient Name)

a copy of this office's Privacy Practices.

___________________________________ __________________
(Signature) (Date)

TO OUR PATIENTS:

WHEN YOU MAKE AN APPOINTMENT WITH US, THAT TIME HAS BEEN RESERVED ESPECIALLY FOR YOU.
WE HAVE MANY OTHER PATIENTS WAITING TO SEE US.
PLEASE BE CONSIDERATE OF OUR TIME AND THE NEEDS OF OTHERS.
IF YOU CANNOT KEEP YOUR APPOINTMENT, PLEASE NOTIFY US AT LEAST 24 HOURS IN ADVANCE.

FAILED APPOINTMENTS WITHOUT NOTICE
WILL RESULT IN A
$40.00 "NO SHOW" FEE.

PATIENTS WITH MEDICAID INSURANCE WILL NOT BE CHARGED A "NO SHOW" FEE BUT WILL NOT BE REAPPOINTED.

I have read and understand the above message:_______________________________
(Signature) (Date)