NEW ORLEANS DENTAL CENTER

Patient's Name: _____ **Patient's Date of Birth:** _____

Financial Responsibility

I authorize the filing of my insurance claims and payment of my dental benefits to New Orleans Dental Center. If I choose to pay for a product or service not covered by MCNA Dental, I understand there is a $30.00 service charge for any returned (NSF) checks.

Scheduling Agreement

We consider your time valuable; therefore, your appointment is reserved just for you. As a courtesy, we will text and/or email you a reminder, two working days before your appointment. If you do not reply, we will try to reach you by phone. We require a 48-hour notice to change or cancel an appointment. (For Monday appointments, we require notice by the previous Thursday). **If three appointments are missed or cancelled without the required notice, you may be dismissed from the practice, and MCNA will be notified.**

Designation of Personal Representative

I authorize the following individual(s) to obtain information or make decisions in regard to my dental treatment and/or dental records:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ (initials) I authorize detailed voice mail messages to be left on my home/cell phone.

Notice of Privacy Practice Acknowledgement

I acknowledge that I have read the New Orleans Dental Center's Notice of Privacy Practices, which contains a complete description of the use and disclosures of my health information.

My signature below certifies that I understand and agree to all of the above.

Signature: _____Date: _____

Print Name: _____ Relationship to patient: _____