NEW ORLEANS DENTAL CENTER

Patient's Name: ____ **Patient's Date of Birth:** ________________

I understand the following 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 to be valuable; therefore, your appointment is **reserved just for you. Appointments are not "double-booked,"** as they are in many medical offices. Therefore, all appointments are considered CONFIRMED at the time the appointment is made. A 48-hour notice is required to change an appointment. (For Monday appointments, we require notice by the previous Thursday). **Please note: in order to maintain an on-time schedule for all of our patients, PLEASE call us in advance if you would like to add or remove a procedure from your scheduled appointment, including a doctor examination of a new issue to discuss.**

If multiple 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 __________________________

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

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: _________________