San Dimas Family Dentistry

Ramzi Sawabini, D.D.S. and Toan D. Nguyen, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____ , have received a copy of the Notice of Privacy Practices for the
Name (Please Print)
Office of Ramzi Sawabini D.D.S. and Toan D. Nguyen D.D.S _____
(Initials)

NOTE: It is your right to refuse to sign this acknowledgement.

OFFICE POLICY

Due to the alarming increase in broken appointments, returned checks and difficulty recollecting we are instituting the following fees.

-Appointments that are cancelled less than 24 hours in advance, or missed will be charged $50.00, or 30% of the procedure if it is an operative procedure.
- Checks made good before we are notified from our bank a $15.00 charge will apply.
- Checks made good during the same week we notify you a $25.00 charge will apply.
- Checks made good the following week after notification a $40.00 charge will apply.
- Checks made good 2 weeks after notification a $50.00 charge will apply.
- Checks not made good after 2 weeks will be sent to collections and/or small claims court for the full amount ($50.00 additional fee applies]

_____
(Initials]

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed by the Doctor to make a thorough diagnosis of the patient's dental needs. 1 also authorize the Doctor to perform all recommended treatment, mutually agreed upon by me, and to use the appropriate medication and therapy that may be indicated for such treatment in connection with treatment of the patient. I further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. I understand that a 1**1/2%** finance charge (18% APR] may be added to my account, in addition to any collection charges. I understand that it is my responsibility to advise your office of any changes in my insurance information, medical information, or any other pertinent information.

Patient: _____Date:_____ Witness:_____
Parent or Responsible Party:_____ Relationship to Patient:_____

PATIENT ACKNOWLEDGEMENT OF

RECEIPT OF DENTAL MATERIALS FACT SHEET

I,_____, acknowledge that I have read and received from
San Dimas Family Dentistry a copy of the Dental materials Fact Sheet dated October 2001.

_____
Patient signature Date