Acknowledgement of Receipt of
Notice of Privacy Practices

I, (Please Print)_______________________________, have received a copy from Scott A. Campbell, DDS on their Notice of Privacy with regards to protected health information privacy policies. I understand that a copy of this notice is available to me anytime at my request.

PATIENT SIGNATURE ____ Date_______________
(or parent/guardian)

Financial Agreement

In order to control the cost of billing, the patient's portion is due at the time the service is rendered. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Any account 90 days past due are subject to collection fees. There will be a service charge on all returned checks.

Payment from your insurance is to be paid directly to Dr. Scott Campbell. All benefits quoted are not a guarantee of payment by your insurance company and you understand that final determination can only be made once the claim has been processed.

PATIENT SIGNATURE ________ ____________________________________ Date________________
(or parent/guardian)