Dr. Beverly Jimenez DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices.

____

Please print child's name

____

Signature (Guardian)

____

Date

*As of April 1, 2017, Annapolis Pediatric Dentistry's (APD) cancellation policy has been updated. Due to the overwhelming amount of missed/failed appointments, our new policy states that if you have **missed or failed appointments** (w/o 24 hr notice) a $25.00 cancellation fee will be applied per child/appointment. After the third failed appointment, your child/children will be **dismissed from APD**. We understand that things happen and life occurs; however, we need to be fair to ALL patients. Thank you for your understanding.

____ ____________

Signature of Parent/Guardian Date

*Here at APD we pride our practice on being efficient and timely. We need your help to be able to do that. **Please arrive on time for your appointments**, if you are more than <u>10 minutes</u> late we will have to reschedule your appointment. We are asking that parents **DO NOT** drop their child/children off and leave the office. It is a HIPPA violation to see a minor without parent/guardian supervision. We appreciate your understanding and cooperation.

____ ____________

Signature of Parent/Guardian