**Easter Seals Notice of Health Information Practices**

**Compliant with the Privacy Regulation of HIPAA**

I have received a copy of the Easter Seals Notice of Information Practices for Release of Health Information in compliance with the Privacy Regulations of HIPAA and am aware of its contents.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**No-Show Policy for Easter Seals Dental Center**

Your dental providers want to make sure that you and other area residents have access to high-quality dental care when you need it. To ensure maximum access to dental services for all of our patients, please be aware of the following appointment policy.

Scheduled Appointments: Although we will make every effort to remind you of your upcoming dental appointment by phone or mail, you are ultimately responsible for remembering your appointment date and time.

Cancelling Appointments: If you cannot make your scheduled appointment, you] must call us at least 24 hours in

advance to let us know so that we can offer your appointment to another patient. Failure to provide at least 24 hours' notice counts as a missed appointment.

Missed Appointments: Because of the critical lack of access to dental services in our area, missed appointments are taken very seriously. If you miss two appointments, you will be discharged from our practice.

Please talk with any of the dental staff if you have any questions about this policy.
I understand and agree to abide by this "No-Show" policy.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature (for patients under 18 yrs.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Restorative Materials Acknowledgement**

I have read and have been offered a copy of the Dental Restorative Materials list and am aware of its contents. .

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE PRINT PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­