



| Patient's Name | | |
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| Financial Acknowledgements | and Authorizations | |
| I agree that whether or not I am payment of all services rendered limitations of the insurance plan acknowledge that I need to give appointment in order for the office assign directly to Dr. Francis, all permission to release all informations. | d. If I have insurance, it is my that I am using for services a my current insurance inform ce to request payment directly insurance benefits otherwise | responsibility to know the at this office. In addition, I ration to this office prior to my ly from my insurance company. I e payable to me, and I give |
| office's responsibility to confirm | my appointment. Cancellatio | nents are scheduled. It is not the ins and/or missed appointments at \$35 per half hour of reserved |
| Notice of Privacy Practices an | nd Dental Materials Fact Sh | eet |
| I have been offered a copy of the Materials Fact Sheet. | e Notice of Privacy Practices | as well as a copy of the Dental |
| | | |
| | | |
| | | |
| Signature | Relationship to Patient | Date |

