Patient Acknowledgement of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of this office's Notice of Privacy Practices (NPP) or that this office's Notice of Privacy Practices was made available to me (Monfredi Family Dental's NPP is available continuously on our website, https://monfredifamilydental.com).

_____ _____

Patient's signature **Date**

_____

Print Legal Guardian's name (if patient is a minor)

_____

Legal Guardian's signature

Office Cancellation Policy

Monfredi Family Dental requires at least 24 hours notice to cancel or reschedule an appointment. If your appointment falls on a Monday, we require notice no later than noon on the previous Friday.

While we understand that things do happen in life, cancellations without notice or "no shows" for confirmed appointments are disruptive to the provider's schedule as well as the other patients we serve. As a result, if you confirm and do not show up for an appointment or cancel under the 24 hour limit, the following fee schedule will apply:

1st Event = $25 fee
2nd Event = $25 fee
3rd Event = $50 fee & We reserve the right to dismiss you from our practice

_____ _____

I agree to the above cancellation policy (signature) Date