Harvey L. Kansol, DDS

Acknowledgment of Receipt of Notice of Privacy Practices
You May Refuse to Sign This Acknowledgement

The undersigned acknowledges that a copy of the currently effective Notice of Privacy Practices for the dental office of Harvey L. Kansol, D.D.S has been offered to me. A copy of this signed, dated Acknowledgement shall be effective as the original.

_____ _____ _____
Please Print Your Name Please Sign Date

If you are the legal representative of the patient(s), please print the patient's name(s) and describe authority
(1) _____ (2) _____
(3) _____ (4) _____

Thank you. Should you have any questions about the Notice, please contact our privacy officer, Harvey L. Kansol, D.D.S.

Office Use Only

As the privacy officer, I attempted to obtain to obtain the patient's (or representative's) signature on the Acknowledgment but did not because:

It was an emergency treatment	_____	The patient refused to sign	_____
I could not communicate with the patient	_____	Other (please describe)	_____

_____
Signature of privacy officer

Authorization and Release

I hereby authorize Dr. Harvey Kansol to take photographs, slides, and/or videos of my face, jaw and teeth. I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television) and professional publications (dental magazines and journals). I further understand that if the photographs, slides and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____
Signature Date

Terms and Conditions

I understand that responsibility for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made beforehand.

In order to insure the most timely care for all patients, please notify us at least 48 hours in advance should you need to reschedule or cancel an appointment. As this time is reserved for you, a $35 charge will be applied for all broken appointments.

Any balance not paid within stated terms will be considered PAST DUE and may be assessed a LATE CHARGE. A LATE CHARGE will be assessed again on each succeeding monthly billing date on which a pat due balance remains. The LATE CHARGE will be assessed at a Periodic Monthly Rate of 1.5%, which is equivalent to an Annual Percentage Rate of 18% or the highest legal rate permitted by applicable law, whichever is less. This LATE CHARGE is the agreed upon liquidated damages for failure to make timely payment and is not a penalty. It is agreed by the parties that this amount fixed as damages is a reasonable forecast of the harm caused by late payment.

In the event that it becomes necessary for the dental office to secure the service of a collection service and/or an attorney to collect any unpaid balance due on the account, I hereby agree to pay all costs incurred by Harvey L. Kansol, D.D.S. in connection with the collection of the account including reasonable collection and/or attorney fees. Venue shall be in Seminole County, Florida.

_____ _____
Signature Date