RICHARD L. THIBODEAU
5285 Summerlin Road Ft. Myers FL 33919
Phone: (239-936-7077) Fax: (239-936-8211)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective notice of privacy practices for Richard Thibodeau D.M.D, _______________, 20_____. A copy of this signed, dated Acknowledgment shall be effective as the original.

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(PLEASE PRINT YOUR NAME)

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(PLEASE SIGN YOUR NAME)

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority

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Thank you and if you have any questions about this form or our Notice, please contact our privacy officer, Richard L. Thibodeau D.M.D

DENTAL BENEFIT EXPLANATION

It is our policy to provide the best dentistry for you. To do this, it is important that we do not let dental benefits be a determining factor in the diagnosis. Your treatment will be based upon your specific needs, and we assume that you are as concerned as we are about maintaining your good health.

As a courtesy to you, we will submit claims to your dental plan carrier. We will also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion at the time the services are provided. However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We will only allow a 60 day hold on insurance payments and then we will bill the balance to your account. We take interest free financing as well. (ask us for more infomation)

I agree and understand these policies reguarding my dental benefits. I also authorize the dentist to release any infomation including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitoners. I authroize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

PATIENT SIGNATURE/ DATE

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