

**EMERALD COAST FAMILY DENTISTRY**

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**Acknowledgement of Receipt of Policies**

I, (print name) \_\_\_\_\_, acknowledge that I have received a copy of the Cancellation and Failed Appointment Policy for Emerald Coast Family Dentistry, P.L., and I hereby agree to comply with the terms and conditions of the Cancellation Policy.

I hereby acknowledge and understand that Emerald Coast Family Dentistry, P.L. reserves the right to revise the Cancellation Policy.

Signature \_\_\_\_\_

Date \_\_\_\_\_

I, (print name) \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices (HIPPA) for Emerald Coast Family Dentistry, P.L.

Signature \_\_\_\_\_

Date \_\_\_\_\_