
ACKNOWLEDGEMENT OF OUR FINANCIAL POLICY AND NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge that I have read the Financial Policy and Notice of Privacy Practices for Northern Star Oral & Maxillofacial Surgery, PLLC. I have had all my questions answered pertaining to these policies. I acknowledge that my signature on this document authorizes the office to submit insurance claims for benefits for services rendered or to be rendered. I also agree to pay any balances not covered by insurance in full.

Patient (or Legal Guardian) signature: _____

I authorize the office to contact me and leave messages at the following:

- Home
- Work
- Cell Phone

I allow the office to discuss matters with:

- Spouse/Significant Other
- Parent/Guardian
- Other: _____

For Office Use Only

We have attempted to obtain written acknowledgement of receipt of our Notices of Privacy Practices, however it could not be obtained due to:

- Individual refused to sign.
- Communication barriers prohibited us from obtaining acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other: _____

