Kennebunk
Center for Dentistry
Kindness. Compassion. Dedication.

Acknowledgment of HIPAA Notice/Privacy Practices

I acknowledge that i have received a copy or may be provided a copy of Kennebunk Center for Dentistry's HIPAA Notice of Privacy.

PRINTED NAME _____ DATE _____

PRINTED NAME OR SIGNATURE OF PERSONAL REPRESENTATIVE: _____

SIGNED NAME: _____

Dental Office Use Only

STAFF SIGNATURE _____ DATE _____

Authority of Personal Representative to Sign for Patient (check one):

- ☐ Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other _____

Receipt of our Notice of Privacy Practices not obtained because:

- ☐ Emergency
- ☐ Unwilling to sign
- ☐ Other _____

Cancellation Policy
A 48 hour notice is required for cancellation/rescheduling for all appointments.
If we do not receive proper notice there will be a $65 fee applied to your account.

I accept and acknowledge: _____