# Craig S. Wilson, DDS, LLC

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND NO SHOW FEE

I, _____, have received a copy of this office's Notice of Privacy Practices. I am also aware that there will be a $75.00 fee for a missed office visit and a $100.00 per hour fee, for a missed treatment appointment for each hour reserved. This is the responsibility of the patient and not billable to your insurance company. Kindly give 48 hours notice to avoid this fee. Please also note that our practice has the policy in place to discharge a patient after two no show appointments.

_____

Please Print Name

_____

Signature

_____

Date

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For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and No Show Fees, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communications barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)_____