

**Gregg C. Hendrickson, DDS**  
**2790 W. Horizon Ridge Pkwy. Ste 100**  
**Henderson, NV 89052**  
**(702) 735-3284**

**Notice of Privacy Practices  
Patient Acknowledgement**

atient Name: \_\_\_\_\_  
Please Print

ate of Birth: \_\_\_\_\_

have received this practice's Notice of Privacy Practices written in plain  
anguage. The Notice provides in detail the uses and disclosures of my  
rotected health information that may be made by this practice, my individual  
ghts, how I may exercise these rights, and the practice's legal duties with  
spect to my information.

understand that this practice reserves the right to change the terms of its  
otice of Privacy Practices, and to make changes regarding all protected  
ealth information resident at, or controlled by, this practice. I understand I  
an obtain this practice's current Notice Privacy Practice on request.

ignature: \_\_\_\_\_

ate: \_\_\_\_\_

elationship to patient (if signed by personal representative of patient):  
\_\_\_\_\_

**CANCELLATION POLICY**

I understand that the office requires that I give sufficient  
notice when canceling a scheduled appointment  
**(At least 48 hours).**

If sufficient notice is not given, I understand that I will be  
charged a **cancellation fee of at least \$50.**

\_\_\_\_\_  
Signature Date

**INSURANCE COVERAGE**

I understand that insurance coverage on my dental services  
before treatment(s) are only **Estimates.**

In many cases, **actual insurance payments are lower** than  
the estimates given by your insurance company.

\_\_\_\_\_  
Signature Date