Auburn Oral Surgery
838 Southbridge St.
Auburn MA 01501

ACKNOWLEDGEMENT OF RECIEPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this dental practice HIPAA notice of privacy practices.

***Is there anyone you would like to authorize to speak to us regarding your account or treatment? ***

Name: _____

Authorization to release medical info if needed

This signature on file is my authorization for the release of any medical information / records, pictures, and prescription lists required by Dr Laith Azzouni / Dr Layeeq Ahmed to obtain clearance for my surgical procedure and treatment planning with your general dentist, done at AUBURN ORAL SURGERY.

XRAY RELEASE and PICTURE RELEASE if needed

I hereby authorize the office to take pictures if required.
I hereby authorize and request the release of my xrays and/ or pictures and email to info@auburnoralsurgeons.com. If my dentist cannot email these over, or not received prior to my appointment, I authorize AOS to take them.

Policy on Payment

Auburn Oral Surgery may, at its option, impose $15 late fees monthly for up to three months should unpaid invoices remain open for more than thirty (30) days. The last fee gets added to your remaining balance. For example, if your balance due is $100.00 and it remains unpaid for over 90 days your new remaining balance will become $145. After 90 days, your account becomes eligible to be placed with a third-party collection agency.

SEDATION PATIENTS ** PLEASE READ BELOW**

Marijuana can affect the way sedation works on you and the amount of anesthesia. The ways you use marijuana (smoking, edibles, etc.), how often you use it, and how much all can affect how your body responds to anesthesia. Since marijuana and anesthesia both affect the central nervous system, the doctor needs to know ahead of time how much and how often you use marijuana.

Text Message

I consent to receive SMS text message from Auburn Oral Surgery for appointment reminders, and general two-way communication. Reply STOP to opt out. Refer to our website for our privacy policy and more information

DATE_____

Patient Name (Please print) _____ Patient Signature_____