# Dr. Esperanza A. Rodriguez

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## PRIVACY PRACTICES ACKNOWLEDGMENT

**I have received the notice of privacy practices and I have been provided an opportunity to review it.**

**Name (print)**

**_____**

**Birth date_____ today' date _____**

**Signature _____sex_____**

**Social ___ ___ ___ ___ ___ ___ ___ ___ ___ ___**

**E-mail_____**

**Address_____**

**City_____ state _____ zip_____**

**phone_____ cellular_____**

In case of emergency, contact _____
Phone_____

## SIGNATURE ON FILE_____

**I authorize use of this form on all my insurance submissions.____**
**I authorize release of information to all my insurance companies.____**
**I understand that I am responsible for my bill.___**
**I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies._____**
**I authorize payment direct to my doctor.____**
**I permit a copy of this authorization to be used in place of the original.____**
**I undertand that I am having the following work done: fillings___ bridges____ crowns____ extractions___ _impacted teeth removed____ general anesthesia_____ root canals_____ other____**