

RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM  
ADA Pamphlet

I, \_\_\_\_\_, have received a copy of Ryan D. McCormick, DMD., P.C. Notice of Privacy Practices.

\_\_\_\_\_  
(Signature of patient or legal guardian)

Date: \_\_\_\_\_

**CASCADEVIEW DENTISTRY**  
**607 NE 3<sup>rd</sup> St**  
**Prineville, OR 97754**  
**(541) 447-3855 --- Office**

## **OUR POLICY OF CARE AND PAYMENT**

ENSURING THAT OUR PATIENTS RECEIVE HIGH QUALITY CARE IS THE GOAL OF OUR PRACTICE.

PAYMENT IS DUE AT THE TIME OF TREATMENT. WE ACCEPT CASH, CHECK, AND MOST MAJOR CREDIT CARDS. WE ALSO HAVE A PAYMENT PLAN CALL CARECREDIT THAT ALLOWS YOU TO START TREATMENT TODAY AND SPREAD PAYMENTS OVER TIME.

### **PAYMENT OPTIONS**

1. CASH
2. CHECK
3. MAJOR CREDIT CARDS
4. CARECREDIT

(APPLYING FOR CARECREDIT ONLY TAKES A FEW MINUTES AND THERE IS NO FEE TO APPLY.)

PLEASE INDICATE THE FORM OF PAYMENTS YOU CHOOSE TO SETTLE YOUR ACCOUNT:

- CASH
- CHECK
- MAJOR CREDIT CARD (Visa, Discover and MasterCard)
- CARECREDIT (subject to credit approval) If credit application is declined, another form of payment listed above is required.

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Signature of Patient/Responsible Party