Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices from time to time that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name_____

Relation to Patient_____

Signature_____

Date_____

We understand that dental treatment may involve an investment of time and money for you and your family. To assist in meeting this financial obligation, the following payment options are offered: 1. Visa/Mastercard 2. Cash 3. Check 4. Care Credit

For services that involve lab work, ½ of the fee is due when treatment is initiated, and the remaining balance is due upon completion of treatment. There is $35.00 charge for returned checks. Fees are subject to change.

Billing Policy

A billing statement will be sent on the 1st of the month specifying any insurance payments (if applicable) and your total balance. After 3 statements, your account will be turned over to our collection agency. Therefore, it is important not to let your account go past due.

Dental Insurance

If you will be using insurance, we will be more than glad to file with your insurance claim as a courtesy to you, our patient. We do want to remind you, that all patients are fully responsible for payments of accounts, and that we do not render services on the basis that insurance companies will pay any and all fees. As a courtesy to our patients, we try to give an **ESTIMATE** of what your insurance will pay for services from information we receive from your insurance representative, but in no way are we responsible nor ever guarantee payments from any insurance company. Please remember your insurance policy is your responsibility. It is a contract between you and the insurance company/employer, not the doctor.

Cancellation Policy

In order to ensure you and the other patients uninterrupted treatment, it is necessary for patients to adhere to all scheduled appointments. Once you have made an appointment, please remember this time is reserved for you. As a courtesy to our patients, a friendly reminder call is made the day before to confirm your appointment. Since our time and yours is so important, we ask that you make your very best effort to notify the office at the earliest time possible if an appointment change is necessary. A $25.00 charge is made to your account if you **DO NOT** give at least a 24 hour notice.

I hereby authorize the staff to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand that the use of certain anesthetic agents may embody certain risks.

I have read, understand, and agree to the above policies:

Print name_____Sign_____Date_____