ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (HIPAA)

I have read and understand about my rights as a patient concerning privacy and the release of my medical information. I know that my records will not be released or shared with anyone without my permission.

List name(s) of anyone (family, etc.) who may have your information:_____

_____Initial

Broken Appointment and Cancellation policy

It is our goal to provide quality dental care for you and your family at a reasonable fee. Broken appointments and cancellations result in non-productive times that inevitably increase our fee to you. **There will be a $50 charge for all missed appointments and cancellations less than 24 hours prior to scheduled appointment time**. We regret this must be instituted and appreciate your understanding as we continue our efforts to provide quality family dentistry in the most efficient manner. _____Initial

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Financial Policy/Insurance Filing

Payment is due when services are rendered. We accept cash, checks, all major credit cards and Care Credit. Our office is not in any network; however, we will file to all insurance companies. You will be responsible for any charges that your insurance does not pay. If any claim is not paid within 60 days the claim will be closed and the balance due will be your responsibility to pay and you will follow up with your insurance for any reimbursements. Please note, there are some insurance providers that pay directly to the patient. In that event you will be responsible for the cost of your treatment when rendered and insurance will reimburse you. _____Initial

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Permission to Release Records to another office

If at any time your records need to be sent to another dentist, **per your request**, we will be glad to, as long as this paper is signed and dated. Occasionally we may need to refer you to another office for treatment, your signature below gives your permission to send radiographs and any pertinent information regarding your care. I give my permission for my dental records to be released per my request/referral to specialist. _____Initial

Please check if it is ok to text and/or leave a message on your voicemail regarding:

____Appointments ____Account Balance ____Treatment Plans ____Prescriptions/Refills

Phone Number: _____

Patient Name (print): _____ Date: _____

Signature: _____