Office Policies

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company.

I understand that if I fail to arrive for my scheduled appointment with less than a 24 hour notice of cancellation, I will be required to pay my non-refundable co-pay when I reschedule my appointment.

I understand that I may be charged 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give my permission for my dentist and clinical team to take any necessary radiographs, study models and photographs to make a compete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photograph for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

I have read, agree to and understand the statements listed above.

Patient's Signature____Date_______________________

HIPPA - Acknowledgement and Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, ____ have received/reviewed a copy of this office's privacy practices.
(print name)

Signature____Date__________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign.
- ○ Communication Barriers
- ○ Other______________________________