HIPAA Notice of Privacy Practices, Financial Agreement
Appointment Cancellation Policy

HIPAA Notice of Privacy Practices

I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this offices Notice of Privacy Practices as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: provide and coordinate treatment among health care providers who may be involved in my care, obtain payment information from third-party payers for my health care services, and conduct normal health care operations. I acknowledge that I have read and agree to the HIPAA Notice of Privacy Practices and a copy is available to me upon request.

Financial Agreement

We gladly accept the following methods of payment: cash, personal checks, VISA, Mastercard, American Express and Care Credit. A returned check fee of $30 applies when a check is returned by your bank.
As a courtesy, we will gladly file your claim with your dental insurance carrier on your behalf and accept the assignment of Dental insurance benefits provided if you agree to the following: You must provide us with an insurance card and all information necessary to verify your coverage. ***Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to the contract; our relationship is with you, not your insurance company. You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to the next.***
Although we may estimate your insurance benefits, we are not responsible for the accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services that we provide are covered by benefits. Benefits differ from company to company***. Fees for non-covered services, along with deductibles and copayments are due at the time of service.***
A finance charge will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1% on the balance left unpaid and owed will be assessed each month until paid. We understand that temporary financial problems may affect timely payment; in those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account accordingly. An account with an unpaid balance past 120 days will be sent to collections unless previous payment arrangement have been made.

Appointment Cancellation Policy
In order to provide the best service to all of our patients, we have a 48 hour notification of cancellation or rescheduling policy. ***If we do not receive a 48 business hour notice, you will be assessed a $50 per hour fee for cancelled time.***

If you wish to have your records released or sent to another office, you will be required to fill out a records release form, and pay any remaining balances on your account prior to receiving your records. Patients without insurance will be provided a written estimation of fee, and payment in full is expected no later than the day of their treatment unless prior arrangements have been made. Signing this form also gives us permission to discuss your medical, dental and billing concerns over the phone and/or email.

Current Phone: ______________________________ Current Email: __________________________________

____ ____
Patient or legal authorized individual signature **Date**

____ ____
Printed name if signed on behalf of the patient **Relationship**