AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Dental Practice will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.

Patient Name: **Acct Number**

Address:

City: State: Zip Code:

E-mail:_____ Phone:

Doctor's Name: **Practice Name:**_____

Practice Address: _____

I hereby authorize the doctor and practice listed above to release the dental information of the patient named above to:

Print Name of Recipient: _____

_____

Address City State Zip

_____

Specify the dental information to be disclosed above:

Purpose: The dental records and information disclosed may only be used for the purpose(s) listed above:
Duration: This authorization shall remain in effect for one year from the date of my signature below unless a different date is specified here_____(date).
Revocation: You or your personal representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of your written request to revoke.
Redisclosure: I understand that information disclosed pursuant to this authorization may no longer be protected under federal privacy law (HIPAA) and could be re-disclosed by the recipient.
A copy of this authorization is as valid as the original. I have the right to receive a copy of this authorization.

Date _____ Signature _____ If Signed by Other than Patient, Indicate Relationship

Chart # _____

Patient Acknowledgement of Notice of Privacy Practices

I, _____ acknowledge that I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me.

_____

Patient's Signature Date

_____

Print Legal Guardian's Name (if patient is a minor)

_____

Legal Guardian's Signature

For office use only:

_____Patient refused a copy of the Notice of Privacy Practices (NPPs).

_____Patient refused to sign Acknowledgement of NPPs.

_____

Print Name (office staff) Date

_____

Signature

Patient /Guardian Name: _____

Dependents: _____ _____

_____ _____

_____ _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality dental care and your optimum oral health.

The following is a statement of our Financial Policy. We require that you read, agree to and sign prior to any treatment.

Please note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Additional fees will be applied for returned checks. All account balances over 90 days are subject to a late fee.

If you pay by cash:

- This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.
- The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur.

If you have insurance:

- As a courtesy to you, we will help you process all of your dental insurance claims. We will provide an insurance estimate to you. Please understand, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. For those services not covered by your insurance, you will receive a Good Faith Estimate showing the expected cost of those items and services based on information known at the time the estimate was created.
- All charges you incur are your responsibility, regardless of your insurance coverage. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. You authorize the release of any information concerning your (or your dependent's) health care advice and treatment provided for the purpose of evaluating and administering
  claims for insurance benefits.
- Deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, is due at the time we provide the service(s) to you.
- Insurance payments are ordinarily received within 45-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected.
- If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment, are responsible for full payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Missed Appointment (s) **and Cancellations:**
Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24-hour notice for cancellations or for
re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and paid at the time services are rendered.

Communications with you: In order to enhance patients' care and experience with us, we may contact you after your visit in order to request feedback on your experience by phone call, SMS text message,
e-mail, voicemail, or mobile application, some of which may be via automated means. We may also listen to and record phone conversations with us for training purposes or to evaluate the quality of our service. By signing below you understand and agree to be contacted in this manner with communications related to this visit, and any future visits. In the future, you may opt-out of receiving text messages by notifying us in writing (including responding via text message). Standard telephone minute and text charges may apply if we contact you.

Patient /Guardian Signature: _____ **Date:**

Office Staff Signature: _____ **Date:**