PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____

Date _____

_____ attempted to obtain patient's acknowledgement but was unable to do so. The reason it was not obtained was _____.

Signature _____

Date _____

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TO ALL OUR PATIENTS

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your cooperation and understanding of our office policies. Please read and initial each item to indicate that you understand and accept these policies.

#1____Payment for service is due at the time services are rendered. We accept cash, checks and credit cards.

#2____We will be happy to process your insurance claim if you provide proof of dental insurance coverage along with all pertinent information.

#3____You are responsible for informing our office of all insurance, address, and phone number changes. If you do not provide the proper documentation, you will be subject to paying the balance for the office visit.

#4____Because your time is as valuable as ours, WE RUN ON TIME. We expect you to run on time as well. In consideration of our other patients, we WILL reschedule your appointment if you arrive more than 15 minutes past your scheduled appointment time.

#5____Our office is now charging a $25.00 fee to the patient if you do not call and cancel your appointment (more if the appointment is for longer than 30 min). To avoid this charge, please call AT LEAST 24 hours in advance. Our answering service is available 24 hours a day, 7 days a week.

#6____I am financially and legally responsible for all charges. This includes those that my insurance carrier "disallows" We realize that temporary financial problems do occur, we encourage you to contact us promptly for assistance in the management of your account. If my account becomes more than 90 days delinquent, it will be sent to collections. Any fees and costs associated with collection efforts will become my responsibility.

#7____Due to the high demand for appointments in this office, we can "forgive" only 3 missed appointments. We must consider ALL of our patients and release you from our care.

#8____It is our policy that patients are seen by appointment only—NO WALK-INS!

We trust that understand and will honor these policies, However, if unusual circumstances should arise, please feel free to discuss them with us so that special consideration might be given.

THANK YOU

SIGANTURE DATE