WELCOME TO OUR PRACTICE

We are genuinely pleased that you have chosen us for your dental care. We will do our best to continue to earn your confidence. Our staff is dedicated to providing you with the most comfortable and technically up-to-date dental care.

We ask that you make every effort to keep your appointments. Missing an appointment disrupts proper sequencing of care and delays completion of your treatment. If you need to reschedule your appointment, please call us at least 24 hours prior to your visit. (Monday would have to be changed by Friday 12:00 pm) Arriving late is sometimes unavoidable, therefore our policy is: If the patient arrives more than 10 minutes late, we will evaluate our schedule to determine if the patient can be seen. In some instances the patient may be asked to reschedule. A broken appointment will be charged at a rate of $85.00 per hour. Should a patient continue to break appointments, we reserve the right to dismiss that patient from the practice.

We will file your insurance for you as a courtesy. Please remember that we have no control over the benefits of your plan, you are the one who chose your insurance and it is your responsibility to be aware of what your benefits are.

If there is an unpaid balance on your account, you will receive a billing letter allowing you 10 working days to pay; at that time if we have not received your payment your card provided below will be debited. I understand that any portion of the estimated amount not paid by my insurance and claims not paid within 60 days will be my responsibility.

1. I choose to have my insurance company pay their portion to your office. I wish to put any unpaid balance on my Credit/Debit Card.
Credit/Debit Card # ______________________________ Exp Date: _______
Signature Panel 3 Digits on back of card (CID) _________

2. I choose to pay the entire fee myself at the time services are rendered and submit my own claims for reimbursement.

PLEASE SIGN BELOW -- I HAVE READ AND UNDERSTAND THE POLICIES.

______________________ ______________________
Print Name Date

____
Signature

PATIENT CONSENT FORM (HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notices of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to this date I revoke this consent is not affected.

Signed this ______day of _____________, 2015

Print Patient Name: ____________________________

Relationship to Patient: _________________________

Signature: ____________________________________

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