Insured or Responsible Party Information

The following is for: ***□The person responsible for payment*** ***□The insurance subscriber***

Name: _____
LAST FIRST MI

Gender: □ Female □ Male □ Other □ Married □ Single □ Other

Social Security #: _____ Birth Date: _____ Employer: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

Phone (Home): _____ (Work): _____ (Cell): _____

~~Notice of Privacy Practices~~

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

Please inform us if you require more information regarding our policy or if you would like a complete copy of our Privacy Practices.

Uses and Disclosure of Health Information:

***Treatment** ***Your Authorization** ***National Security**
***Payment** ***Required By Law** ***To Your Family and Friends** ***Appointment Reminder**
***Abuse or Neglect** ***Healthcare Operations** ***Persons Involved In Your Care**

Acknowledgement of Receipt of Office Privacy Practices

I, _____ have reviewed a copy of this office's Notice of Privacy Practices.

_____ Date: _____ Relationship to Patient: _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____

For Office Use Only: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: □ Individual refused to sign □ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement □

Other (Please Specify): _____

Consent for Services

I hereby give consent for the doctor and staff to perform such diagnostic, photographic, and therapeutic procedures as may be necessary on me or my child. As a condition of your treatment by this office, payment is due at the time of service. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Missed appointments will be charged at the rate of a normal office visit, unless cancelled **48 hours in advance**.

A rebilling fee of $20 per month on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial agreements are satisfied. A collection fee of 1/3 of your delinquent balance will be added to your principal due.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered, or within five days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder. **You are entitled to a copy of this form.**

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship: _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

_____ Date: _____ Relationship: _____
SIGNATURE OF GUARANTOR OF PAYMENT/RESPONSIBLE PART