

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices ACKNOWLEDGEMENT, but was unable to do so as documented below:

Date:	Initials:	Reason:

## OUR OFFICE POLICY

Thank you for choosing us as your dentist. Your oral health is important to us. We welcome any questions you may have.

**APPOINTMENTS:** You have your choice of dentist for treatment. Should you have an emergency during office hours – one of the doctor's will be happy to see you if your doctor of choice has a full schedule or is out of the office. After hours there is a doctor on call that's left on our recorder at the end of the day.

**PAYMENT:** Payment is expected in full at time of services rendered. Lab cases (crowns, partials, etc.) will require a deposit of half at prep appointment. Balance is due when your work is completed. We have a Healthcare credit card you can apply for – ask front desk.

**INSURANCE:** Insurance is done by our office as a courtesy. We are not a PPC provider of any type of insurance. We will begin working with your insurance when you become an established patient, which is considered your first cleaning appointment. Please bring your dental insurance information with you. Deposits are asked for all lab work. Your deductible and percentage at each visit, please come prepared with payment of cash, check, or credit card. You may owe in addition to what we ask for up front due to what your insurance allowance fee is. Your insurance will only pay a percentage or what they allow – not what we charge. Payment is expected within 45 days from date of service. If your insurance has not paid, you will be asked to pay at that time and we will be happy to help you get reimbursement from your insurance company. We do not file or wait on payment from secondary insurance. Payment is due after primary payment or within 45 days, whichever comes first. We recommend what you need for your oral health not for what your insurance will pay for. We will be happy to do a pre-estimate of your treatment before major work is done. This takes 4-8 weeks for a reply and you should wait to hear from your insurance or us before you begin if you need to know how much you will have to pay. If you have a dental handbook we will be happy to review it with you by appointment. **THANK YOU.**

**I HAVE READ THE ABOVE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL PAYMENTS OF SERVICES RENDERED.**

Signature \_\_\_\_\_

Date \_\_\_\_\_