Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the office of Elite Dental Specialists. The Statement of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Elite Dental Specialists reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective, I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosures of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY: ☐ yes ☐ no

SPOUSE ONLY: ☐ yes ☐ no

OTHER (**PLEASE SPECIFY):**

_____

Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____

Date _____

Description of Personal Representative's Authority _____

-OVER-

Appointment Cancellation Policy

When you schedule an appointment in our office we reserve that time specifically for you. If you need to cancel or reschedule your appointment, we require 24 hours advance notice so that we can schedule another patient waiting for treatment. If you miss your appointment or do not give 24-hour notice, there may be a $75 charge applied to your account. _____ (Please Initial)

Office Financial Policy

Insurance

If you have dental insurance, we will make a good faith estimate of the amount your insurance carrier may pay based on the information provided to us. As the insured, it is your responsibility to determine the coverage by your insurance for any dental service provided in our office. As a courtesy, we will file all dental claims on your behalf as well as provide any information required by your insurance carrier to ensure it is processed in a timely manner. If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filling your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. All questions regarding your insurance benefits must be addressed to your insurance carrier. _____ (Please Initial)

Payment

The amount estimated to be your portion of treatment, is due at the time dental treatment is provided. We accept payment in the form of Cash/Check, Visa, MasterCard, American Express, Discover, and Debit cards.

Patient Responsibility, Assignment and Release

I acknowledge my responsibility for the total payment of all services performed in this office in accordance with their regular fees and terms.

I understand my responsibility is not modified by whether any third party (insurance) pays for all, part, or none of the charges. I understand that any estimated portion, not covered by insurance is due at the time of service for all services rendered.

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize the release of any medical/dental care information requested by my insurance carrier, and authorize my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an exceptional experience!

I have read and understand the Office Financial and Appointment Cancellation Policies.

Name of Patient _____

Patient Signature _____

Date _____

Guardian Signature _____