ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Print Name _____
Signature _____
Date _____
YOU MAY REFUSE TO SIGN THIS PRIVACY ACKNOWLEDGEMENT

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:
Individual refused to sign ____
Communication barriers prohibited ____
Emergency situation prevented us ____

Our staff is committed to providing you with the very best possible care! With your assistance and understanding we can share a mutual respect that will lead to a long lasting relationship. In order to achieve this goal, we would like to make you aware of our payment policies. We make every effort to explain your treatment needs and costs to you up front so that we can avoid any misunderstandings. If you have any questions, please do not hesitate to ask. We are here to serve you.

MISSED OR BROKEN APPOINTMENTS

We strive to see all of our patients on time. Each appointment that is scheduled for you is a time that has been specifically reserved just for you. If you need to change your appointment kindly give us a 3 day notice so that your appointment time can be filled.

ANYONE MISSING OR CANCELLING AN APPOINTMENT WITH LESS THAN A 48 HOUR NOTICE WILL BE SUBJECT TO A $50 CHARGE PER HOUR SCHEDULED.

Exceptions may be considered in the event of illness or if the appointment time can be filled. If broken appointments become a chronic problem, we reserve the right to dismiss you from the office.

PATIENT FINANCIAL POLICY

1. Payment is due at the time services are rendered unless payment arrangements have been approved by our staff. We accept cash, MasterCard, Visa, American Express and Discover. Emergency visits for all new patients must be paid in full unless dental insurance can be verified.
2. Balances older than 30 days will be subject to interest charges of 1.5% per month. In the event that payment is not made for services after a reasonable period of time, our attorney will be advised and formal action to collect will be initiated. You will be responsible for any attorney's fees and/or collection expenses.
3. Our staff will estimate your co-pay for each visit and this amount will be due at the time of service.

ALL CHARGES ARE YOUR RESPONSIBILITY AND MUST BE PAID WITHIN 45 DAYS FROM THE DATE SERVICES ARE RENDERED; REGARDLESS OF INSURANCE.

4. I authorize and direct payments of the dental benefits directly to Dentistry4You and consent to disclosure of my protected dental health information to carry out payment of benefits.

I have read, understood and accept the terms stated above. I have been given a copy of this document.

Signature _____ Date _____