Notice of Privacy Practices for Protected Health Information

I, _____________________________, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

-Payment Policy:

As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated.

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

Payment in full is required at time of service. If you have insurance, your copay and/or deductible is required at time of service. **________Initial**

-Missed appointment/Cancellation policy:

Our office policy states that missing three (3) appointments without notifying us prior to appointment will result in dismissal from our practice. Keeping your appointments is an important part of the quality of your healthcare. We reserve the right to apply a $25.00 cancellation fee to your account if your appointment is canceled within 24 hours of the appointment time or you do not show for your appointment. **________Initial**

________________________________ ___________________________

Signature Date