

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES
Flint Hills Dental PA

I, _____, hereby acknowledge that I have received and reviewed a copy of Flint Hills Dental PA's *HIPAA Notice of Privacy Practices*.

I understand that Flint Hills Dental PA's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Flint Hills Dental PA's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Flint Hills Dental PA's *HIPAA Notice of Privacy Practices*, I may contact the Privacy Officer at (785) 321-3455.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Flint Hills Dental PA will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the US Department of Health and Human Services should I have concerns regarding Flint Hills Dental PA's privacy policies and procedures. For information on how to contact the US Department of Health and Human Services, please ask the Privacy Officer, noted above, for assistance.

Patient Signature

Date

Signature of Parent or Guardian

Relationship to Patient

Patient gives consent to share Health Information with the following family members:

FINANCIAL AGREEMENT

At this time, we would like to thank you for choosing our team for your dental health care! We are happy to serve you and will do our best in every way to provide you with a pleasant experience. Please take a moment to read and sign the following Financial Agreement, and if you have any questions, please do not hesitate to ask us.

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. We understand insurance guidelines can be difficult to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility. All insurance co-pays and deductibles must be paid at the time of service. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims. We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. I realize I am financially responsible for all charges incurred, regardless of insurance coverage.

Please contact our office when you receive a friendly reminder so that we may move forward and God Bless!

Respectfully,
Flint Hills Dental, PA

Responsible Party Signature

Date

Appointments cancelled within 24 hours of scheduled time are subject to a \$50 cancellation fee