ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________________, have received a copy of the office's Notice of Privacy Practices.

Signature: ______________________________________

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name ____________________Relationship to patient________________________

PATIENT TREATMENT AND FINANCIAL POLICY

The following is a statement of our financial policy, which we require that you read, agree to and sign prior to treatment.

Payment:

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and Care Credit.

Additional fees will be applied for returned checks, and or any account submitted to an outside collection agency.

Insurance:

As a courtesy to you we will help to submit dental insurance claims for the treatment we provide. We offer basic calculated estimates of your insurance coverage. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.

All charges you incur are your responsibility, regardless of insurance coverage. Your insurance policy is a contract between you and your insurance company.

Unaccompanied minors:

The parent or legal guardian is responsible for payment at the time of service. Treatment consents and payment arrangements must be made with the parent or legal guardian prior to an unaccompanied minor may be seen for any dental appointments.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that payment for dental services provided in this office for myself or my dependents is my responsibility, due and payable at the time services are rendered.

________________________________	________________________________	________________
Patient/Parent name (Print)	**Signature**	**Date**