Dimples Family Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

*** You May Refuse to Sign This Acknowledgment***

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

From the Business Office

Please note that our relationship is with you and not your insurance carrier. Just as your dentist is interested in assisting you clinically, the office staff are here to help you in dealing with the business matters. As such we find it best that you understand the financial responsibility you have for your treatment. Please keep us aware of changes in your address, phone numbers or insurance information.

First Visit

We accept assignment of varying insurance plans. **If proper authorization has been received, patients covered by insurance carriers will be asked to make their co-payment only.** If you are not covered by an insurance carrier, you will be expected to make payment in full at the time of service.

Subsequent Visits

Upon determining your co-payment amount (and your annual deductible has been met), **you are expected to make your co-payment at each visit.** If your insurance carrier does not consider your treatment necessary or chooses not to pay for the treatment, you will be responsible for the charges.

Method of Payment

Cash, Personal Check, Visa, MasterCard, or **Discover** can be used at the time of service. **CareCredit,** a credit card strictly for medical/dental treatment, can also be used. More information on this program is provided at the front desk or by any staff member. For patient's that do not have insurance, we offer a cash/check discount of 5% when services are paid in full on the date of that service. Cash discount does not apply to co-payment.

Cancellations

Your dentist has reserved time to see you. If you find you are unable to keep your appointment, please give the business office at least 48 hours notice. Failure to give this notice may result in a charge of $60 per reserved treatment hour, and will be billed to your address.

Payment Authorization

I, _____, hereby authorize Dimples Family Dentistry to release information concerning my treatment. I direct the insurer to pay directly to Dimples Family Dentistry all benefits due to them as a result of my dental claims. Although insurance may be effective, I am aware that I am personally responsible for all other charges in which insurance did not cover. If my portion of the charges are not paid to Dimples Family Dentistry within 30 days, I understand I will receive monthly finance charges until the amount is paid in full. **In the case of my failure to comply with payment of co-pays, new charges or outstanding balances, I authorize Dimples Family Dentistry to verify employment for collection purposes. An additional administration fee of $25 will be added to my account if my account is referred to a collection agency.**

Signature of patient or guardian _____ Date _____

SUBSCRIBER

Authorization for Signature on File

Authorization of Payment

_____ hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the office of **Dimples Family Dentistry.**

This "Signature on File" will be valid from this date
and shall expire in one year.
A photocopy of this document may act as an original.

_____ Today's Date

_____ Signature of Subscriber

_____ Expiration Date

_____ Witnessed By