

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I have been made aware of the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____
Parent's Signature: _____
Relation to Patient: _____ Date: _____

Financial Policy

Our financial policy is designed to make it affordable for you to have a dental care that you need or want. We have worked very hard to create various payment options for our patients, and have come up with financial arrangements that will allow virtually anyone to have the very best dentistry available.

We accept Visa, MasterCard, Discover, and American Express credit cards, Cash or checks. Monthly payments plans are not accepted, but we can help you apply for an outside credit plan, Care Credit. Any NSF checks will be charged out at \$30.00 per return. If a check is returned twice it will be turned over to the District Attorney's office.

Most dental insurance plans are accepted; **however we are not in-network with ANY commercial insurance company except for Delta Dental.** For those of you with insurance, you will be responsible for any estimated portion not covered by your insurance company. If however there has been no response from your insurance company after 30 days you will be ultimately responsible for any unpaid balance. We will provide any information necessary in an effort to maximize your benefits.

I have read the above financial policy and agree to comply accordingly.

SIGNED: _____ DATE: _____