ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES

OPTIONAL: Name of Personal Representative, Family Member, or anyone else whom you want to grant authorized access to your protected health information regarding treatment, appointments, billing and other inquiries.

☐ I authorize release of all information to: _____

☐ CHECK HERE IF YOU REQUEST A COMPLETE COPY OF THE NOTICE OF PRIVACY PRACTICE DATED 04/04/2003.

SIGN BELOW AGREEING TO HIPAA & NOTICE OF PRIVACY PRACTICE.

Signature: _____ **Date** _____

FINANCIAL POLICY

For your convenience we offer several options of payment: Cash, Check, Debit or Credit Card. We also have companies willing to finance dental treatment with no money down. Payment arrangements must be agreed upon before procedure is initiated. If you have dental insurance, we will gladly file your claim for you; however, you are responsible for your account. ***Each patient will receive an estimate for treatment needed, which will include their co-pays and deductibles. This is only an estimate and you are responsible for amounts not paid by the insurance. We cannot guarantee what insurance will or will not pay***. As a courtesy, we will submit your secondary insurance claims for you, with secondary payments going to the subscriber. If your insurance neglects to pay within 60 days, the balance on the account becomes your responsibility. If your account becomes delinquent, it will be turned over to a local collection agency and you will incur any collection costs and any related attorney's fees. If you do not have dental insurance, we do have other payment options, you may discuss with options with our financial coordinator. All estimated payments are due at time of service.

Patient Initial _____

We are committed to superior service with the latest in technology, done in a timely manner. ***We reserve the right to charge $50.00 per hour for all broken/cancelled appointments that do not allow 48-hour notice. For any major treatment, you will be expected to apply a reservation fee payment at the time of scheduling***. As our patient, we ask that you keep your account current to allow us to continue providing our highest level of care for you, your family and friends. Your account will be charged a return check fee in the amount of $35 for any check returned unpaid.

Patient Initial _____

By signing below, I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to Kopit Dental Care.

Please read carefully before signing this agreement.

Print Name:_____

Signature:_____Date:_____/_____/_____

Print Name:_____