HIPPA PATIENT ACKNOWLEDGEMENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Pendleton Family Dentistry. A copy of the signed and dated acknowledgement shall be as effective as the original.

My signature will also serve as a phi document release should I request documents be sent to other attending doctors/treatment facilities in the future.

Patient name (printed: ________________________________ Date: ______________

Patient signature: ____________________________________

Parent signature (if minor): _____________________________

Please list any other parties who can have access to your healthcare information: (this includes any caretakers, step parents, and/or grandparents)

Name: ________________________________ Relationship: ____________________

Name: ________________________________ Relationship: ____________________

I authorize information about my healthcare be conveyed via:

___ Cell phone confirmation

___ Home phone confirmation

___ Work phone confirmation

___ Text message to cell phone

___ Email confirmation

___ Any of the above

Office use only:

As a privacy officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because:

___ It was emergency treatment

___ The patient refused to sign

___ I could not communicate with the patient

___ The patient was unable to sign

___ Other: ____

Signature of Privacy Office: Pendleton Family Dentistry

PATIENT FINANCIAL INFORMATION

Welcome to our practice! Thank you for selecting our dental health care team. Please read the terms and conditions and initial on the lines below.

___ I authorize the dentist to release any information including the diagnosis, records of my treatment, and/or examination rendered to me during the period of such dental care to a third-party payer and/or health practitioners.

___ I authorize and hereby request my insurance company, if applicable, to pay directly to the dentist insurance benefits otherwise payable to me.

___ I understand that your office files my insurance claims as a courtesy and that in good faith you take assignment of my insurance. If I should receive the insurance check, I will pay the balance owed to my account.

___ I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself and dependents.

___ I realize that failure to keep this account current may result in you being unable to provide additional dental services except in dental emergencies or where there is a prepayment for additional services. In the case of default on payment of this account, I agree that reasonable collection agency fees equal to 50% of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

___ We require that you pay the deductible, co-payment, and co-insurance, which is an estimated amount not covered by your insurance company, *by cash, check MasterCard, Visa, Discover, American Express, or CareCredit at the time of service,* unless prior arrangements have been made.

Missed Appointment(s) and Cancellations:

In order to provide the best services to our patients, we require at least a ***2-business day notice for cancellations OR for re-scheduling your appointments, otherwise, a $50 late cancellation or no-show fee will be added to your account.*** We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment. Multiple failed appointments may require having to pre-pay for future appointments.

I have read, understand, and agree to the above terms and conditions. I understand that responsibility for dental services provided in this office for myself and/or my dependents is mine, due and payable at the time services are rendered.

Patient's name printed: ____

Patient's signature: ____

Parent's signature (if minor): __________________________ Date: ____________