INSURANCE AUTHORIZATION

- I authorize my insurance company to pay the dentist all insurance benefits rendered.
- I authorize the use of this electronic signature on al insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

_____Initial

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the cost incurred in their care.

Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies as a courtesy and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our changes will be paid by the insurance company.

I understand that any fee estimate for this dental care is in fact an estimate and not a guaranteed price as the insurance company may not cover the full percentage that is used to determine patient portion.

I understand that any fee estimate or treatment plan provided can only be extended for six (6) months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be billed.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

**_____Initial *

Cancellation Policy

We understand that issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance.

Our doctors and hygienists want to be available for your needs, as well as the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have had a cancellation policy, circumstances have caused us to enforce a policy of charging for No-Show appointments and those appointments not cancelled withing 48 hours. If we do not receive a call to cancel the appointment, there will be a fee of $50 assessed on all hygiene appointments and a fee $50-$125 fee (determined based on type of procedure and length of time needed for procedure) for appointments scheduled with doctor.

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

**_____Initial *

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care provider and the payment for my health care will not be affected if I refuse to sign this form.

I understand that the information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

**_____Initial *

***By initialing, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Insurance Authorization, Financial Policy, Cancellation Policy, and HIPAA Disclosure Form.**