

PRINT NAME _____
LAST FIRST

_____/_____/_____
DATE

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY ACT OF PRACTICES

Dentex Dental Group, LTD – Dental Medicine Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. In addition to the copy we will provide you, copies of the current notice may be obtained throughout our offices.

BY SIGNING THIS FORM BELOW I ACKNOWLEDGE THE RECEIPT OF THE NOTICE OF PRIVACY ACT OF PRACTICES.

SIGNATURE X _____

PAYMENT AND APPOINTMENT CANCELLATION POLICY

PAYMENT POLICY

We make every effort to minimize the cost of your care. You can help by paying in full at each visit. You may request an estimate of the charges for any procedure prior to the start of work. We feel everyone benefits when there is a definite and clear financial agreement prior to treatment. To make your financial arrangement as easy as possible, we accept Cash, Money Order, Visa, and MasterCard. **We do not accept personal checks.**

Payment in full is due the day of treatment. Some procedure charges may be made in several installments, depending on the length of treatment, but must be paid in full upon procedure completion. Insurance claims will be submitted to your carrier for all covered services.

Your deductible and co-pay, if any, will be due and collected at the time of service! No payment arrangement may be used with this option. If your carrier has been charged, it is your responsibility to notify us.

We will be happy to file your insurance as a courtesy, however, any balance still due after 90 days will become the patient's responsibility. We will also be happy to help explaining your insurance benefits to you, but it is ultimately the patient's responsibility to know their insurance benefits and to make sure that their claims are paid in a timely manner. Your insurance is a contract between you, your employer, and the insurance company.

APPOINTMENT CANCELLATION POLICY

It is your responsibility to keep your appointment. If you are unable to keep an appointment, kindly give us at least 24 hours notice. Any appointment that is failed or canceled with less than 24 hours notice will result in **\$25.00 Appointment Cancellation Fee***. This charge must be paid before another appointment will be scheduled. Unless it is an emergency as determined by the attending doctor, Dentex Dental Group may refuse services if:

1. You have not met any unpaid balance.
2. You have canceled 5 (five) times during a calendar year (by calling 24 hours in advance to appointment).
3. You have 2 (two) or more broken appointments during a calendar year (by not calling to cancel an appointment at least 24 hours prior to appointment time).

We reserve the right to reschedule or refuse to schedule any appointments in the future if any of these cases apply to you. We also reserve the right to reschedule your appointment if your doctor is sick or in any case of similar emergency situation.

I HAVE READ AND FULLY ACCEPT THE POLICIES MENTIONED ABOVE. THIS SIGNATURE ON FILE IS MY AUTHORIZATION FOR THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM, AND THAT I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES INCURRED.

* DOES NOT APPLY TO SOME GOVERNMENT ASSISTANCE PLANS

SIGNATURE X _____