

**DOTHAN PERIODONTICS & IMPLANTS
RELEASE OF MEDICAL INFORMATION & FINANCIAL POLICY**

Your medical information is personal and we are committed to protect this information. We create a record of the care and services you receive at our office and these records are used to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your general dentist or one of our employees.

IN ORDER TO RELEASE YOUR PERSONAL INFORMATION, INCLUDING LAB RESULTS, TEST RESULTS OR FINANCIAL MATTERS, TO ANYONE OTHER THAN YOURSELF, PLEASE READ AND SIGN IN DESIGNATED AREA(S) BELOW

The following describes the different ways that your information may be used or disclosed by this office.

For Treatment: We use medical information about you to provide you with medical treatment and services. We may disclose medical info about you to your referring dentist, doctors, nurses, technicians, and other office personnel who are involved in providing you treatment. _____ **Initial**

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. _____ **Initial**

For Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care. I grant permission to Dothan Periodontics & Implants, its employees and/or agents the right to contact me via home phone, work phone, cell phone, email or any other means I have provided in order to notify me of any future appointments, changed appointments. You may be charged \$50 for no show visit.

**May we leave messages for follow-up appointments ___home___office___cell___email

_____ **Initial**

As Required By Law: We will disclose medical information about you when required to do so by federal, state, or local law. _____ **Initial**

I have read and understand the above and agree to the conditions listed and initialed above

Signed: _____ Date: _____

For Insurance and Collections: Our office does not participate with any insurance company as a provider, but we will file your claims with your insurance company and assist you with any supplemental forms, if we are given the necessary information at the time of your initial service. Your insurance is a contract between you (the Subscriber), your employer and the insurance company; we are not a party to that contract. I hereby make assignment of all dental, disability, surgical, medical and major insurance benefits to Dr. John Miller and Dr. Daniel Pittman, *dba* Dothan Periodontics & Implants to release any medical information necessary to execute an assignment of benefits. I understand that regardless of any insurance coverage, I am personally responsible for all charges to this account.

I further agree in the event of non-payment, to accept the cost of collection, and/or court cost and reasonable legal fees should this be necessary. The cost of collection (33.33%) will be added to all delinquent accounts at the time they are placed with a collection agency. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

Payment in full is due at the time of service. We accept Cash, Checks, Debit Cards, all major credit cards and Care Credit as forms of payment. You will be charged a \$35.00 bank fee for any returned checks for any reason.

By my signature below, I indicate that I have been informed of and agree to the privacy practices of Dothan Periodontics & Implants.

Signature _____ **Printed name:** _____ **Date** _____