Welcome! Thank you for choosing us as your dental care provider! We understand dental treatment represents a significant investment both time wise and financially. We are committed to addressing both the clinical and financial aspects of your dental treatment in our office.

****By initialing on the line, I understand the information and agree with its contents.*

______**Regarding Payment**

We accept the following forms of payment: Cash, Check, Visa, MasterCard, American Express, and Care Credit. Payment is due at the time the services are rendered. This includes all insurance co-insurance and deductibles. We will do our best to give you an accurate estimate but you are ultimately liable for anything insurance does not cover.

______**Regarding Dental Benefits**

We will work closely with your insurance company to maximize use of your annual benefit and minimize your out-of-pocket expense. We will never let your insurance companies dictate what we can/cannot recommend as treatment based on your diagnosis. We will tell you exactly what services are recommended by the Doctor(s) and/or Hygienist(s) in order to treat and/or control the diagnosed conditions. We will do our best to give you an accurate estimate with the information we are provided by both you and your insurance company.

______**Regarding Cancellations**

Patients are responsible for scheduled appointments. As a courtesy, we provide multiple appointment confirmations electronically as well as via phone. If a patient arrives after the scheduled start time, the appointment may need to be rescheduled so that we perform all the necessary procedures and still respectfully stay on schedule for other patients. We value our patient's time. Please provide us with a minimum of 48 hours advance notice to avoid a $50 cancellation/missed appointment fee.

______**Acknowledgements of HIPPA Privacy Practices**

I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to: - Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly and indirectly. - Obtain payment from third-party payers for my health care services. - Conduct normal health care operations such as quality assessment and improvement activities. I have been informed of my Dental Providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review a copy of such Notices of Privacy Practices, I understand that my dental provider has the right to change the Notices of Privacy Practices and that I may contact this office at the address above to obtain a copy of the Notice of Privacy Practice.

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Responsible Party Name (printed):

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Responsible Party Name (signature): **Date:**