Acknowledgement of Receipt of Privacy Practices Notice

Clermont Family Dentistry

Section A: The Patient

Name: _____

Address:_____

Home phone:_____ Cell phone:_____

Section B: Acknowledgement of Receipt of Privacy Notice

I, _____acknowledge that I have revieved a Notice of Privacy Practices from the above named Practice.

[ ] You may discuss my dental treatment with the following person(s):

_____

_____

[ ] Please do not discuss my dental treatment with anyone.

Signature:_____ Date:_____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Clermont Family Dentistry & Dentures

Office Policy

Patient Name: _____ Birth Date:____/_____/_____

Thank you for choosing our practice for your dental health care needs. We are committed to providing you with the best possible care.

1. **Payment**

Payment is due at the time services are rendered unless arrangements have been approved in advance. Please be prepared to make payment including insurance co-payments during each scheduled appointment.

- For your convenience you may pay by Cash, Visa, Mastercard or Discover.
- 0% Financing is available with approved credit. Please ask us for details.
- Financial responsibility for patients that are minors lies with the parent who accompanies the child to appointment. Minors should be accompanied by a parent to answer any questions with regards to treatment or patient care.

2. **Insurance**

If you have dental insurance, we would be pleased to assist you in receiving your maximum allowable benefits. Our staff will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize however;

1. Your insurance is a contract between you, your employer, and your insurance company.
2. The insurance coverage you will receive depends upon the quality of the plan purchased by the employer. Plans vary greatly and insurance companies do not give us the exact reimbursement amounts. These reimbursements are ESTIMATES, please contact your insurance if you need an exact reimbursement amount.
3. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Any remaining balance 30 (thirty) days after we have filed a claim becomes your responsibility and is due and payable. A service charge of 18% per annum accrues on any portion of a balance remaining over 90 (ninety) days.
4. Please be aware that any unpaid amount by your dental insurance will be the responsibility of the patient receiving treatment.

3. **Broken Appointments**

Your appointment is scheduled specifically for you. Therefore, we require a **cancellation or reschedule** notice of 48 business hours. If such a notice is not given, or you fail to show up for your appointment, a $75 fee (the minimum cost of your appointment) will be charged to your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to assist you.

☐ **By checking this box and signing below, I agree that I have read the above Financial Policy and agree to all payment terms. I further authorize the office to release any information concerning my case to my insurance company**

_____ _____

Patient Signature Date