Clermont Family Dentistry

12344 Roper Blvd ◆ Clermont, Fl 34711
Phone (352) 242-1763 ◆ *Fax* (352) 242-6376

Assignment and Release

I the undersigned, have insurance with _____, and assign directly Clermont Family Dentistry all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy

I hereby agree to be responsible for the costs of care provided by Clermont Family Dentistry and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s). I understand that if I pay by check and the check is returned, I will be charged a $25 fee to cover the bank charge.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 2-business days prior to my scheduled appointment time. ***For appointments scheduled for 90 minutes or longer, I will be required to make a reservation fee of $75 prior to scheduling the appointment, which will be applied to my out-of-pocket expense for the appointment. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited. For appointments scheduled for less than 90 minutes, a cancellation fee may apply if I do not provide notice of cancellation at least 2-business days prior to my scheduled appointment time.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than three hundred dollars ($300) payment in full is due at the time of service. I understand that after 45 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office within 60 days will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Minor/Child Consent

I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Clermont Family Dentistry

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Clermont Family Dentistry. I hereby authorize, as indicated by my signature below, Clermont Family Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed:_____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

4._____ Date Added / Removed: _____

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____