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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I can receive a *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

If you wish to designate a person to be given access to all or part of your medical record, please write their name below:

Name: _____ Relationship: _____

PAYMENT POLICY

1. Payment is expected at the time the service is rendered. We will accept cash, personal checks, and the following credit cards: Discover, Visa, MasterCard, and American Express.

2. Non-insured patients are expected to make payment in full on the day the service is rendered, unless definite arrangements have been made with our Office Manager in advance.

3. Financial arrangements can be made prior to treatment with the Office Manager. The doctor will not discuss financial arrangements with the patient. Once an arrangement is agreed upon, it must be paid with a credit card on file with a maximum period of 3 months. Your credit card will automatically be charged on a monthly basis.

4. Patients with dental insurance are expected to pay the applicable deductible and the portion of the total fee not covered by their insurance on the day of service. The estimate provided by this office is to be considered a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated.

5. All balances are due within 30 days of billing statement. Patient is responsible for a 3% finance charge incurred for balances not paid within 30 days.

6. If the account is placed with a third party for collection, the patient is responsible for any additional fees placed on the account.

7. There will be a $35 fee for any returned checks.

I have read the above policies and agree to abide by them.

Signature: _____

Patient Name:_____ Date: _____

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