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***Acknowledgement of Practice Procedures***

**My Signature/initials below certify that I acknowledge, understand and assume all responsibility for this office's policies in accordance with insurance, appointments, payment and HIPAA Privacy Act.**

 I acknowledge that I am expected to pay for services rendered at the time of my visit; by method of cash, check, Visa, MasterCard or Discover. For delinquent accounts, interest rate charges of 1.5% per month and 18% annually will be assessed. Minimum finance charges are $5.00.

 I realize that in the event my account becomes 90 days delinquent and proceeds to collection status: there will be significant charges added to my account that I will be responsible for.

 In the event that a check is returned from the bank a $50.00 fee will be charged in addition to the amount of the returned check.

 **I acknowledge that Dr. Steinberg is not a participating provider for any dental**

**benefit plans. I agree to assign my insurance payments to be paid directly to**

**Tore D. Steinberg, D.D.S., P.C. In the event that my insurance company sends**

**Payment directly to me, I will be responsible for full payment at time of services.**

 I accept that any estimates given are only ***approximations*** and that I am responsible for the balance of my dental account ***regardless*** of my insurance.

 I agree that if I need to change my pre-scheduled appointment time I must supply 48 business hours notice. This notice must be made directly to the front office staff. **Voicemail cancellation will not be accepted**.

 I understand that a broken and missed appointment creates scheduling problems for other patients as well as the practice. Without my sufficient notification the office will be unable to offer this time to another patient. therefore, it will be necessary to charge a $50.00 fee for a broken or missed appointment.

 I have been shown and read the Notice of Privacy Practices. I also understand that a copy will be provided to me at y request.

 By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment or health care operations as described in the Notice of Privacy Practices.

**I acknowledge that my signature below indicates my understanding and cooperation with**

 **the above statements. All questions and concerns have been answered to my satisfaction.**

 ***Signature*** ***Date***

***A copy of this form will be provided upon your request.***