Patient: _____ Preferred Name: _____

Last *First* *MI*

Consent for Services and Financial Policy

As a condition of treatment by Stone Creek, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care.
Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

This office will help prepare the patient's insurance forms or assist in making collections from insurance companies. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any remaining balance after insurance's response, will be billed to the patient.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that in the event any amount(s) is/are referred to a third party debt collection agency, I agree to pay a collection fee of 25%, interest, court costs, and reasonable attorney's fees.

A charge of $50 will be applied to my account if I do not give 48 hour notice to cancel or reschedule any of my dental appointments.

Initial: _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Names and Relationships to Patient: _____
(Names & Self, Parent, or Spouse, etc.)

Initial: _____

To the best of my knowledge, the questions on this form have been accurately answered.
I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes to my health/medications, insurance/financial information.

_____ _____

SIGNATURE OF PATIENT, PARENT, GUARDIAN **DATE**