



# Financial Policy Informed Consent

Patient: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Last First MI

## FINANCIALLY RESPONSIBLE PARTY (GUARANTOR)

Relationship to Patient:  Self  Spouse  Mother  Father  Other \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_-\_\_\_-\_\_\_

Phone: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_ (Other) \_\_\_\_\_

Address: \_\_\_\_\_  
Line 1 Line 2

City State Zip

**Initials** If you are over the age of 18, even if another person is listed above, you remain financially responsible for the balance accrued at Stone Creek Dental. The financially responsible party listed above will be the first point of contact for all bills and you will be the second point of contact. In the event your account becomes delinquent, you will be the party sent to collections.

## APPOINTMENTS

**Initials** Stone Creek Dental requires a notice of two business days for cancellation or rescheduling of an appointment. We reserve the right to charge \$50 if a notice of two business days is not provided. Appointments are confirmed by our automated system. If we are unable to reach you, we trust that you will keep your scheduled appointment. If a patient arrives more than 10 minutes late we reserve the right to mark it as a missed appointment and reschedule the appointment.

## DENTAL INSURANCE

**Initials** I understand that all balances accrued at Stone Creek Dental on my account are my responsibility. As a courtesy to those with dental insurance that supply the office with the insurance information prior to treatment, Stone Creek Dental will file a claim on their behalf. It is my responsibility to know my dental insurance policy and be familiar with my coverage and maximums. **All deductibles, co-pays, and patient percentage amounts are due at the time of service. I understand I am responsible for any remaining balance that is not covered by my insurance company for any reason.** All treatment estimates are provided based upon information from my insurance company and are estimates only.

**Initials** I give my permission for Stone Creek Dental to release necessary information regarding my treatment to my insurance company(s) and assign dental benefits payment directly to Stone Creek Dental. I authorize the release of treatment information to Stone Creek Dental.

## FINANCIAL POLICY

**Initials** **Payment is due at time of service.** We accept Cash, Checks, Visa, MasterCard, or Discover. We also offer CareCredit (upon approval) for patients who wish to make monthly payments. Applications for CareCredit must be completed before any dental treatment is started. Return checks will be charged a fee of \$25. An interest fee of 2.08% compounding monthly (25% per annum) on unpaid balances will be charged on all accounts exceeding 60 days past 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 processing fee, a collection fee of 25%, interest, court costs, and reasonable attorney's fees.

**I have read the above conditions of treatment and financial responsibility and agree to their content.**

**SIGNATURE OF PATIENT, PARENT, GUARDIAN**

**DATE**

**MORE ON BACK SIDE**

# Protected Health Information Release and HIPAA Notice of Privacy Practices

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). There are rules and restrictions on who may see or be notified of my PHI. Stone Creek Dental has adopted the following policies regarding the privacy of my PHI. Stone Creek Dental may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

## PATIENT INFORMATION

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to my care are handled appropriately. I agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
- I understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

## PATIENT COMMUNICATION

**Initials** I understand Stone Creek Dental may remind me of my appointments, discuss my health information with me, notify me of changes to office policy, and/or send me other communications via various means such as: text, phone call/voicemail, e-mail, and/or U.S. mail. I consent to receiving communication to the phone number(s) and addresses that have been provided to Stone Creek Dental that may contain my PHI.

Besides being able to communicate with me, Stone Creek Dental may communicate with people I designate as authorized by me. **I authorize the following people to receive communication on my behalf:**

- Parent(s) \_\_\_\_\_
- Spouse \_\_\_\_\_
- Other \_\_\_\_\_ Relationship \_\_\_\_\_

## GENERAL POLICY

Stone Creek Dental will provide me with access to my records in accordance with state and federal laws. I have the right to request restrictions in the use of my PHI and to request changes in certain policies used within the office concerning my PHI. I agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor. I understand I may receive more detailed HIPAA information upon request.

**I hereby consent and acknowledge my agreement to the terms set forth in this form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**SIGNATURE OF PATIENT, PARENT, GUARDIAN**

**DATE**

## Treatment Informed Consent

**I authorize any doctors, hygienists, and/or designated assistants to perform those treatments as may be deemed necessary or advisable** to maintain the dental health and comfort of the patient listed on this form. This includes the arrangement and/or administration of pharmaceutical agents including but not limited to; sedatives (such as nitrous oxide), analgesic, and therapeutic agents which may be used in restorative, palliative, therapeutic or surgical treatments. I understand that the performance of these treatments and administration of pharmaceutical agents may cause unplanned reactions or side effects; such as bruising, hematoma, cardiac stimulation, temporary or permanent numbness.

**I do voluntarily assume any possible risks associated with treatment** for the benefit of the patient listed on this form. I acknowledge that the nature and purpose of the preceding treatments have been explained to me if necessary and I have been given the opportunity to ask questions.

**SIGNATURE OF PATIENT, PARENT, GUARDIAN**

**DATE**