**RULAND FAMILY DENTISTRY, P.A.**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, FINANCIAL POLICY AND INFORMED CONSENT**

Thank you for choosing us as your health care provider. The following is our financial policy and informed consent. Our main concern is that you receive the proper and optimal treatments needed to restore your health. If you have any questions or concerns about our payment policy please contact our office.

 We ask that all patients read and sign our Financial Policy and Informed Consent prior to seeing the doctor.

 Payment for services are due at the time services are rendered. In effort to provide you with flexible payment arrangements, we have expanded our office payment policy. We accept cash, check, credit card and Care Credit. We will be happy to process your insurance claim for you but wish to make it clear that your insurance policy is a contract between you, your employer, and your insurance company. **OUR** relationship is with you, **not** your insurance company. As a result, all charges are your responsibility whether or not your Insurance company pays. Not all services are a covered benefit in all Insurance contracts and any pre-estimate quotes are **not** a guarantee of benefits.

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs,

and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis

 of dental need.

1. Upon such diagnosis, I authorize doctor to perform all recommended treatment

mutually agreed upon by me and employ such assistance as required to provide proper

 care.

1. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully

 understand that using anesthetic agents embodies certain risks. I understand that I can

 ask for a complete recital of any possible complications.

1. **Balances due are billed out monthly** and must be paid in full before any further treatment can be rendered. Any accounts 90 days overdue will be subject to a 16% APR finance charge.
2. I agree that in the event this account becomes delinquent due to non-payment and is

 turned over to an outside collections attorney or agent, I agree to pay all actual and

 reasonable fees, legal fees, cost, expenses and court costs incurred in the collection of

 this account.

1. I agree to pay a $35.00 returned check fee.
2. **Confirmation Policy**: As a courtesy, attempts are made to confirm all appointments 24 to 48 hours prior to appointment by e-mail, text or phone call.
3. I understand that if I fail to appear to a scheduled appointment or cancel an appointment with less than 24 hours’ notice, there may be a failed appointment fee which I agree to pay before any further appointments can be rescheduled.
4. Inclement **weather**: In the event of inclement weather conditions (i.e., snow) contact

 our office the day of your appointment to be certain we are operational.

We understand that temporary financial problems may effect timely payments of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

 I understand that, under the Health Insurance Portability & 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 understand I may request a copy of the office’s *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 at the address above to obtain a current copy of the *Notice of Private Practices.*

 I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

 I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_