ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____,have received/reviewed a copy of

INVERNESS FAMILY DENTISTRY, PC Notice of Privacy Practices.

_____

Print Patient Name

_____

Signature

_____/_____/_____

Date

Authorization to Release Information

I, _____, authorize the following persons(6) to have access to information

covered under the Privacy Act to people other than yourself.

_____ _____

(Please print) Relationship

_____ _____

(Please print) Relationship

_____ _____

(Please print) Relationship

Do we have your permission to leave messages on voice mail or and answering machine? YES NO

_ _

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could no be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #:_____ Birth Date: _____

Phone (Home):_____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost 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.

Patients who carry dental insurance should understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that all charges will be paid by an insurance company. Ultimately, all fees are the full financial responsibility of the patient or guarantor regardless of insurance coverage.

A service charge of 1½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements have been satisfied.

I understand that all fee estimates listed for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for professional services rendered to me, or at my request by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees of collecting any amounts past due including, but not limited to, attorney's fees and cost and court cost.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent, or guardian

_____ Date:_____ Relationship to Patient:_____
Signature of patient, parent, or guardian