Policies & Agreements

Patient Name ____

Please read & initial each one

________**Appointment Policy:** When an appointment is made in our office, we reserve that time in our day specifically to attend your dental needs. If you are unable to keep an appointment time, we request a 24 hour notice of conflict, or there will be a charge added to the account. Please keep in mind that after 2pm on a Friday is considered less than 24 hours. We will make every effort to contact you regarding your appointed time as a courtesy reminder.

________**Financial & Insurance Policy:** In return for dental services provided to the patient, I agree to pay Signature Smile Family Dentistry for their charges, less any adjustments necessitated by contractual agreement or governmental regulation. I understand that payments which are due, but which have not been paid, from insurance benefits do NOT reduce my obligation to pay the patient's account. I also agree to reimburse the practice for any additional expense that it incurs if the account goes to collection. Such expenses will include collection agency charges, reasonable attorney fees, and court cost. There will be an NSF fee of $20.00 for all returned checks.

________**HIPAA & Privacy Policy**: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I have read and consent to all above policies & agreements.

Patient/Patient's Guardian Signature: ___________________________________ Date: ___________