HIPAA Privacy Policy-Acknowledgment

Patient Consent and Financial Agreement

We keep a record of the health care services we provide you. You may ask to see and copy these records. You may also ask to have these records corrected. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about them by contacting the Medical Records/Privacy Officer or Office Manager.

- Patient agrees to release of medical or other information to process claim.
- Patient agrees to accept assignment of payment
- Patient gave permission to leave a message on their answering machine
- Patient gave permission to discuss their medical condition with another person (your emergency contact.)

*____I hereby authorize treatment by *South Shore Dental.* I understand that I am financially responsible for all charges incurred for services rendered regardless of litigation, insurance reimbursement, or pending Labor & industry Claims. I understand that the parent accompanying a minor for any treatment will be responsible for payment. I authorize the release of any necessary information requested by my insurance company and/or attorney. I authorize payment directly to South Shore Dental.

*____I understand that ALL co-payments, and/or out of pocket payments, are due on the day of treatment. We have a signed contract with most insurance companies that state w are to collect co-pay on the day of your scheduled appointment. It is the patient's responsibility to verify dental coverage and co-payment.

*____I am committed to my health and attending my dental appointments. I understand in the event that I need **to cancel** my appointment, I will provide South Shore Dental with a **48 hour** cancellation notice in order to avoid a **$50 fee**, payable prior to my next visit.

*____I understand, in the event I do not show up for my appointment all future appointments may be cancelled until I call for new appointments.

*____All patient balances older than 60 days are subject to a 5% per month interest/billing charge. Please note that balances over 90 days may be sent to a collection agency.

By my signature below, I acknowledge that I am aware of the Notice of Privacy Practices and authorize the above-mentioned release of information.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of patient Relationship

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