PLEASE READ AND SIGN BELOW EACH SECTION

Payment is due in full upon services rendered

If you have insurance coverage, our staff will calculate estimated insurance payments for services rendered. We can not, however, be responsible for the actual payment made by your insurance carrier. You are required to make payment of your full estimated responsibility upon services rendered. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit issued to you.

Signature of Patient/Parent/Guardian **Date**

Commitment to appointment agreement

Your appointment time with the Doctor or the Hygienist is reserved exclusively for you. An appointment with your name on it is a bond of trust that you will be present for that appointment and that we will be here to take care of your needs. Last minute changes in the schedule not only affect the doctor, but other patients as well. Many times we get calls from patients who are in pain and wish to be seen right away, which is difficult to do if we are booked. For this reason we cannot accept constant short- notice changes or cancellations. If you find that you cannot keep your appointment, kindly give us the courtesy of 48 hours notice so that we may fill the time with a patient who needs it. Any cancellations less than 24 hours notice or no shows are subject to be charged a fee of $25 for every 15 minutes that was set aside for your appointment. We do not accept recorded messages as appointment cancellations or changes.

A reminder call is given 1 to 2 days prior to your appointment time as a courtesy to our patients. However, you are ultimately responsible for all appointments made. The care and consideration of our patients is of the utmost importance to us. In return we must ask for your consideration and respect for our time.

We value you as a patient and look forward to a long lasting and pleasant relationship with you. We appreciate your understanding and cooperation in this matter.

Signature of Patient/Parent/Guardian **Date**

Continue on next page →

Patient Consent Form (HIPAA)

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____

Signature _____ Date_____

I, _____ give crescent dental permission to leave any information regarding my health on my answering machine/voice mail (_Yes _No) and/or with the following person(s):

(print names of any person(s) allowed access to your dental information)

_____

_____

_____

Signature _____ Date _____+ _____