Smile Design
DENTISTRY

NOTICE OF PRIVACY PRACTICES

Please initial to indicate approval:

____ Assignment of Benefits: I hereby request that payment of insurance benefits to be made directly to Smile Design Dentistry on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to the services rendered to my dependent or myself. If for any reason my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

_____PATIENTS RIGHT TO PRIVACY: I acknowledge I have been made aware of Smile Design Dentistry's privacy practices. If I would like a copy of the HIPAA notice I will ask for one.

_____AUTHORIZATION TO DISCUSS HIPAA PROTECTED INFORMATION:

I give Smile Design Dentistry permission to share my medical and account information with:

Name:_____ Relationship_____

_____**RELEASE OF MEDICAL RECORDS:** I authorize the release of medical information to any dentist/healthcare provider involved in my care and also as necessary to process insurance claims and applications.

____**CANCELLATION POLICY:** When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us by phone with advanced notice of two business days. We understand that conflicts arise; however failing your appointment or canceling without adequate notice will result in up to a $100 charge and then discontinuation of services.

INSURANCE & FINANCIAL AGREEMENT

Though your dental insurance is your responsibility, we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help you by filing your insurance forms. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense. Patients without insurance are eligible for our Smile Design Dentistry package, please ask for details.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast the exact disbursement of insurance benefits.

Financial Responsibility

I acknowledge that I understand that payment of my estimated portion of the services fee is expected at the time of service unless a payment plan is agreed and established on my behalf.

_____I have read this form and certify that I understand its contents as of this date

_____ _____

Patient or Responsible Party Signature **Date**