NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; (2) obtain payment from third-party payers and (3) conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

FINANCIAL POLICY ACKNOWLEDGEMENT

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. In order to achieve these goals, we need your assistance and understanding of our financial policy. For the convenience of our patients, we offer the following methods of payment: (1) payment in full by cash or check, (2) Visa, Mastercard & Discover and (3) Care Credit which can provide you with an interest free payment plan.
If you have dental insurance, we are happy to help you receive your maximum allowable benefits. **However, it is important for you to realize the following: (1) your dental insurance policy is a contract between your employer and the dental insurance carrier. Pineland Family Dentistry is not a part of that contract**. (2) While we are happy to look into your insurance benefits for you and file claims on your behalf. This is done as a courtesy for you. **You are ultimately responsible for understanding your insurance benefits prior to treatment.** Balances due to insurance denials are the patient's responsibility regardless of the reason for the denial. (3) We do accept assignment of benefits from your insurance. Therefore, you will be given an *estimate* of how much we expect the insurance to pay and how much your *anticipated* out of pocket will be. We will collect your anticipated out of pocket expense at the time of service. **However, ultimately the full cost of treatment is the responsibility of the insured, not the insurance company**. (4) Please be aware that when bringing in a minor for treatment, the parent or guardian bringing the child in is responsible for any payment due for that child on the day of service. (5) As stated above, we do accept assignment of benefits from our insurance company. By signing below, you state that you are aware of this and authorize your insurance company to issue payment directly to Pineland Family Dentistry on your behalf. (6) A finance charge of approximately 1% may be charged to balances over 90 days past due.

RESERVED APPOINTMENT POLICY

We greatly value you and your commitment to excellent dental health. In order to care for you effectively, we ask that you pre-schedule your next preventative visit prior to leaving the office to ensure that you stay on track with your necessary dental treatment. These semi-annual or quarterly "cleanings" will help to prevent the need for further, more invasive and costly dental treatments. It is imperative that you stay on schedule for this routine, preventative care.
When we schedule appointments for patients in this office, we are very careful to allow a generous amount of time for each of our patients with both the doctor and the hygienist. The time allowed is very important for you to receive the individualized care that you deserve. Reserved appointment time is for patients who are committed to completing their necessary dentistry. To be fair to all our patients, **we require a notice of two business days** if you need to change (reschedule) your appointment for an urgent reason. Because we preschedule our patients six months in advance, it is difficult to get you back into the schedule in a short period of time. ***Therefore, we ask that when you commit to a time, you make it a priority in your schedule.***
As a courtesy, we offer reminder calls, emails and text messages in advance of your appointment. All these options are available to you. Let us know if you prefer one over another and we will do our best to accommodate you. **When you receive these reminders, it is important for you to follow the directions provided and confirm your appointment**. Please understand that an appointment is ultimately a reservation with the doctor and/or hygienist. We ask that you do all you can to arrange your schedule in a way that will enable you to be here for your appointed time. A No Show/Late Cancellation is defined as a failed appointment.
We do understand that sometimes things come up that are beyond your control and you may not be able to be here for your reserved time. Therefore, we offer **one *excused* appointment** for any reason rather work related, illness related, family emergency or car trouble, that you were not able to provide a two business days' notice. **A second occurrence will result in a $50.00 failed appointment fee.**
If there is a third occurrence, there will be a $50.00 failed appointment fee and we will require a credit card be held on file for all future appointments
A fourth failed appointment will result in a $50.00 failed appointment fee and we will no longer be able to offer you reserved appointments any longer. We will be happy to see you in our office when a last-minute opening becomes available. If you miss three or more appointments within a year, you may be dismissed from our practice.

By signing below I acknowledge that I have read, understand, and agree to the office *Financial Policy Acknowledgement, Reserved Appointment Policy,* and *Notice of Privacy Practices.* I also acknowledge that I have had the opportunity to have any questions answered.

_____ _____
Patient/Parent or Guardian Signature Date

❑ Patient ❑ Parent ❑ Guardian ❑ Other _____