adiska
FAMILY DENTAL

PATIENT RELEASE/HIPAA/FINANCIAL POLICY

Patient Name: _____

Thank you for the confidence you have shown in choosing us to provide for your dental needs. We are pleased to assist with your insurance (if applicable); however, you are ultimately responsible for payment of your bill.

1. **AUTHORIZATION TO RELEASE INFORMATION :** I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails without special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below-named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

   _____ **Please Circle: Spouse Parent Child Other**

   Signature of Patient/Legal Guardian: _____ **Date:** _____

2. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES :** I acknowledge that The Notice of Privacy Practices is kept at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the Notice and one will be provided to me.

   Signature of Patient/Legal Guardian: _____ **Date:** _____

3. **FINANCIAL RESPONSIBILITY:** I understand I am personally responsible for any fees/copays I incur for services rendered and that those fees are due at the time of service. (For minor patients, the accompanying adult and parents/guardian are responsible for full payment.) I acknowledge I am responsible for any charges incurred by not providing the most current, correct insurance at time of service. Finance charges may be assessed against overdue accounts. In the event any fees are unpaid and it becomes necessary to pursue collection efforts, I agree to pay all costs directly associated with such collection efforts. I acknowledge any demographic information provided by me, including my cellular phone number, may be used to contact me for any purpose, including collection efforts. I also understand that unless I cancel an appointment 24 hours in advance, the policy is to charge $50 per missed appointment.

   I authorize payment for services rendered to be paid by any third party; including, but not limited To, insurance carriers directly to Adiska Family Dental.

   Signature of Patient/Legal Guardian: _____ **Date:** _____