Tommy L. Kim DDS, PA

OFFICE POLICY

By my signature, I indicate that I have read the **office policy**, understand the **cancellation** and **financial policy** and its content and agree to its provision.

Signature _____ **Date** _____

HIPAA

I, hereby acknowledge that I have read the Notice of Privacy Practices of Prosperity Park Center for Dentistry which sets forth the ways in which my personal dental health information may be used or disclosed by Prosperity Park Center for Dentistry, and outlines my rights with respect to such information.

Signature _____ **Date** _____

INSURANCE

I understand that I will be informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information related to this claim.

Signature _____ **Date** _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Tommy L. Kim. If I do not consent to have payments payable to Dr. Tommy L. Kim, I understand that I will be responsible for payment in full at each visit and will be responsible for filing my own claim.

Signature _____ **Date** _____