OAK CANYON DENTISTRY

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g., my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your **Notice of Privacy Practices,** which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Financial Policy

Cancelled Appointments: If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule. This will allow us to provide that time slot to another patient. In consideration of our hourly overhead expense, a $50.00 fee will be charged for any appointment not cancelled within 24 hours prior to the schedule time. Initial_____

No Insurance: Payment is due in full at the time of service

Insurance: With insurance plans where we have agreed to participate in the network as a provider, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is requirement placed on you by your insurance carrier. If we are out of network, you will be required to pay co-insurance,

deductibles and non-covered services. As a courtesy for our patients, we will file your claim electronically. You are responsible for any balance not paid by your insurance company. You will receive a statement from our office indicating what your insurance has paid. Any balance remaining 45 days after date of service is due in full upon receipt.

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by Oak Canyon Dentistry regardless of insurance coverage or lack of. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including deductibles and co-pays. I understand payment of my co-pay is expected at time of service, as well as any prior balance I may owe. I agree to interest fees of 1.5%/month of any balance over 30 days and all collection costs in the event of default of payment of my charges.

Communication:

I give Oak Canyon Dentistry permission to contact me by: TEXT message and/or EMAIL

Circle which method you would like or both if you prefer.

Date _____

Print Patient Name _____

Relationship to Patient _____

Signature _____