Fee Authorization & Privacy Practices Acknowledgement

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to my dentist on any unpaid bills for services furnished by my family or me. I authorize the release of any dental information necessary to process this claim and all future claims. I also authorize electronic transmissions of dental information including radiographs for use by specialists that I may be referred to.

Forms of Payment

Payment in full of all co-pays, deductibles, and non-covered services by your insurance company is required at the time of service. For your convenience we accept, **Cash, Check, Visa, Mastercard, and Care Credit.**

I have read and understand Dental Associates' *Notice of Privacy Practices.* 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 of obtain a current copy of the *Notice of Privacy Practices.*

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:____________ Initials:__________ Reason:______________________________