Slaughter & Slaughter Family Dentistry, PC

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Please review and sign.

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Slaughter and Slaughter Family Dentistry. I understand that my dental insurance may pay less than the actual bill and I agree to be responsible for the remaining balance.

Sign:_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability 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: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, Obtain payment from third-party payers, Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosers 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Print Patient Name:_____ Signature:_____

Relationship to Patient:_____ Date:_____

Please list all parties with whom you would like for our office to share your information

_____

_____

_____

_____

CONSENT

I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

TERMS AND CONDITIONS

FINANCIAL POLICY
PAYMENT IN FULL IS EXPECTED AT THE TIME OF TREATMENT.
If you have dental insurance, see below for more details.
#1 CASH - This includes personal and cashier's checks, and money orders
#2 CREDIT CARD - Cards accepted include Discover, Visa, MasterCard, Visa debit, American Express
#3 CARE CREDIT - This is a dental line of credit that can cover your family's dental needs. There is no pre-payment penalty and no interest if the balance is paid by the due date. More details are available.
YOUR DEDUCTIBLE AND CO-PAYMENT IS DUE THE DAY OF YOUR DENTAL VISIT. ALL CLAIMS NOT PAID BY YOUR INSURANCE WITHIN 60 DAYS THEN BECOMES YOUR RESPONSIBILITY, AND MUST BE PAID TO US IN FULL. IT IS UP TO YOU TO HAVE REIMBURSEMENT BY YOUR INSURANCE COMPANY.
In an extended service, we will file and process your dental claims for you. If dental treatment is necessary, we will estimate the portion of your dental treatment not covered by your insurance contract, this estimate (co-payment) is due at the start of any dental treatment. Our estimates are based on the information you have furnished us regarding the benefits of the insurance plan your company has chosen. We are not involved with your insurance contract and we cannot guarantee what your insurance will pay. Any balance not paid by insurance within 30 days will be billed to the patient and is due immediately.

CANCELLATION POLICY
Our time is very important to us and to our patients. If you are unable to keep an appointment, we expect a MINIMUM of 24 hour notice. Failure to do so will result in a fee of $75 per cancellation. After three failed/short notice cancellations occur, you may be asked for either a non-refundable deposit and/or full pre-payment of services for that appointment.

I have read the supplied information on HIPAA policies and I accept the release of information.

Signed _____ **Date** _____

There may be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

Please list all medications

_____

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_____

_____

Office Use Only

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

Date:_____ Initials:_____ Reason:_____