Chestnut Dental

Name: _____ **Date of Birth:** _____
Printed

ACKNOWLEDGEMENT OF PRIVACY POLICIES

Part 1. Notice of privacy practices: *I have read the office's posted* Notice of Privacy Practices *and agree to this policy to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and regulations. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals and may be used and disclosed for treatment, payment, or healthcare operations. In the space below, list any family member we CAN share information with:*

Name: _____ Name: _____
Name: _____ Name: _____
Name: _____ Name: _____

Sign here for Parts 1 ➔ X

Signature of ☐ Patient or ☐ Guardian Date

EMERGENCY CONTACT

Name: _____ Relationship: _____

Emergency Contact Phone # _____ Alt Phone # _____

Do we have permission to call EMS on your behalf? ☐Yes ☐No Hospital Preference: _____

AUTHORIZATION FOR IMAGING

Part 2. *I hereby authorize this office to take photographs, slides, and/or videos of my face, jaws, and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publication, newspapers, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or videos are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.*

Sign here for Parts 2 ➔ X

Signature of ☐ Patient or ☐ Guardian Date

FINANCIAL POLICY

Part 3. Payment is due at the time treatment is rendered. For your convenience, we accept Cash, Credit Cards, Checks, Money Orders and financing through several third-party treatment financing companies. Our administrative staff will be happy to explain financing options with you.

For patients with Dental Insurance: Your dental insurance benefits are determined by your employer and not by the dentist or our office. Dental insurance is not a guarantee of payment and insurance benefits will NOT pay for all cost involved with treatment. Your insurance policy is a contract between your insurance carrier and you. Any deductible or estimated co-payment will be due at the time treatment is rendered. As a courtesy to you, we will gladly file your insurance claim. Like our patients without insurance, if the office does not receive payment from your carrier within 45 days, any remaining balance is considered your responsibility and is due and subject to billing charges.

By signing below, you hereby authorize this office to affix your name to any and all claims or documents as related to any dental benefits due through your insurance. You hereby authorize payment of dental benefits directly to this dental office. This "Signature on File" will be valid from this date and shall continue unless you cancel the authorization through written notice to this office.

You understand that, if you do not pay your entire balance within 25 days of the monthly billing date, a service charge of a minimum of $5.00 and a maximum of $25.00 will be added to the account for each monthly billing period. In the case of default of payment, you promise to pay any and all collection costs incurred to effect collection of this account. There is a returned check fee of $50.

Appointments are reserved exclusively for you. We strive for no failed appointments in our office… Only rescheduled treatment. We understand that the will be illness or emergencies that may arise; however, late canceled appointments or failed appointments not only affect in delaying delivery of your healthcare, but affect others in need of care who may have needed an appointment. For this reason, we reserve the right to charge $1 for each minute of lost appointment time if a reserved appointment is canceled or failed without 48 hours advanced notice.

Sign here for Parts 3 ➔ X

Signature of ☐ Patient or ☐ Guardian Effective Date