Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) 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 or indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessments and certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 at the address above 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 the treatment, payment, or healthcare operations. I also understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that, because I am 18 years old or older, my information may not be shared with anyone, including family members, without my express written consent.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Print Name Signature

_____

Date

Georgetown Dental Financial Policy

Welcome to Georgetown Dental. We are happy to have you as our patient and look forward to offering you and your family the finest dental care available. We know that providing complete comprehensive dental services includes discussing all treatment and financial information. We do not dictate your treatment but educate and provide you the available options, regardless of cost. Before treatment is performed, we will discuss treatment and financial options. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements.

Payment is due at the time services are rendered. For your convenience we accept cash, checks, Visa, MasterCard, Discover, American Express, and money orders.

Emergency patients, new to our practice, should expect to make a payment at the time of service. Once established as an active patient, we will be happy to discuss other payment options.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if an opening arises. If an appointment is not canceled at least 24 hours in advance, or if you fail to keep your appointment, you will be charged a seventy-five-dollar ($75) fee. Any missed appointment 1 1/2 hours or more in length will incur a one hundred and fifty-dollar ($150) fee. This fee will not be covered by your insurance company.

Payment plans and financial arrangements are available for comprehensive dental treatment. Please speak to us to make arrangements prior to commencing treatment.

Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. As a courtesy, we will file your claim for you if you provide your dental insurance information and all required employer information.

I understand that if I provide incorrect insurance information leading to Georgetown Dental filing a dental claim improperly, **I will be responsible for a $36 administrative fee.**

Any deductible or estimated co-payment amount will be due at the time of treatment.
I understand and acknowledge that I am financially responsible regardless of insurance coverage. If payment for services already rendered has not been paid in full within 90 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.

I understand that should my payment by check be returned for any reason there will be a charge to me of $75 and I understand that should my account be placed with an agency or attorney for collection, then I agree to be responsible for collection fees equal to 35% of my past due account, as well as attorney's fees, interest of 1.5% per month (18% per annum) and all court costs.
I have read and understand this financial policy.

_____	_____	_____
Printed Name	Signature	Date