HALFMOON FAMILY DENTAL

1456 Vischer Ferry Rd.
Halfmoon, NY 12065
Telephone: (518) 348-1999

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability 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 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 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.

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

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

--OVER--

PHILOSOPHY

Your oral health is our top priority. We strive to provide you with the highest quality dental care available today. That is why we keep abreast of new dental techniques in order to continually improve our professional skill and judgement. More importantly, we are sensitive to our patient's feelings and encourage open communication about your dental needs.

FINANCIAL POLICY

Payment is due on the day service is rendered unless prior arrangements have been made.

We will bill dental insurance, but you are expected to pay your estimated insurance co-payments for services rendered on the day of service. If insurance reimbursement is not received in the office within 45 days, you will be billed for the balance due. We cannot be responsible for actual payment made by your insurance carrier. Insurance estimates and pre-authorizations are not a guarantee from your insurance company. Your insurance policy is a contract between your employer and your insurance company. Therefore, if treatment is dependent upon insurance coverage, we suggest you call your insurance company for an exact payment amount. We will be happy to assist in providing the necessary information you may need. After payments are received from your insurance carrier, you may be required to make additional payments or have a credit issued to you.

Your cooperation with this policy will ensure equitable treatment of insured and non-insured patients. Accounts 30 days past due are subject to a minimum $2.00 service charge or 1.5% per month carrying charge on the existing balance. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

APPOINTMENTS

We will attempt to address all dental emergencies promptly. Your comfort is of tremendous importance to us and we will do all we can to ensure this.

We would also like to make you aware that failure to keep your appointment, or cancelling without sufficient notification, preferably 24 hours in advance, will result in the billing of a $50.00 fee. It is our sincere hope that this will allow our staff to provide you with the excellent care and affordable costs that you deserve.

We thank you for your cooperation.

Signature:_____ Date:_____