Patient name_____

Notice of HIPAA Privacy Practices

We will only use your private information to provide treatment and to procure payment. This means that we may need to share your information with another office providing specialty care for you, your insurance, or with our electronic billing service. We will not share your information with anyone else without your permission.

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding my care.

_____ _____

(Please print name) Relationship

We would like to send you reminder texts, phone calls and postcards. Is this OK with you? Yes_____ No _____

CANCELATION POLICY

We reserve your appointment time just for you, and we require a minimum of 24 hours notice to change an appointment. All appointment changes must be made on the phone during regular office hours (Monday-Thursday, 8-5), as our text and voicemail are not monitored for schedule changes. Cancellations without a 24-hour notice are subject to a $50 charge.

Initials:_____

FINANCIAL POLICY

As a condition of your treatment by this office, payment is due at time of service. The fee estimates for dental care are valid for six months from the date of consultation.

Financial responsibility on the part of each patient must be determined before treatment. In cases of shared custody of a minor child, the parent signing this form shall be the responsible party.

Patients who carry dental benefits understand that they are personally responsible for payment of all dental services. Dr. Dorrough makes his treatment recommendations based on what is best for your dental health, rather than what dental benefits may cover. This office does its best to verify insurance eligibility and benefits and to estimate out of pocket expenses, but cannot guarantee insurance payment. Estimated out of pocket expenses are due at time of service. We will prepare and submit the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections received to patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party collection agency.

Payment may be made by cash, check, debit or credit card. Flexible financing is offered through Care Credit, subject to approval.

_____ _____

Signature Date