OFFICE FINANCIAL POLICY

- I understand that I am responsible for all fees related to my dental care and treatment.
- I understand that full payment for all dental treatment is to be paid at the time the treatment is performed.
- I understand that any and all account balances over 30 days old may incur a monthly interest charge at the maximum rate allowed.
- I understand that if a check, or other instrument, or any electronic authorization or debit sent or provided to Simply Children's Dentistry, Inc. for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument or electronic authorization is later honored, I will be charged the maximum allowable service charge of $30.
- I understand that if my account is not timely paid, my account may be turned over to a collection agency. In addition to paying my balance, I agree to pay all reasonable attorney's fees, collection and/or other court costs.

BROKEN AND/OR MISSED APPOINTMENTS

- Simply Children's Dentistry, Inc. reserves the right to charge a $35 fee for any appointment not kept by the patient. After two (2) broken or missed appointments, the dentist retains the right to discontinue elective treatment.

PATIENTS WITH DENTAL INSURANCES

- I understand that my insurance policy is a contract between My Insurance Company and myself. Simply Children's Dentistry, Inc. and its employees are not parties to my contract with my insurance.
- I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay a balance and later does not pay.
- I understand that I may be given the option of only paying my estimated portion (that portion not covered by insurance) at the time of services. As a courtesy, the office will send my claim to my insurance company. If my insurance company fails to pay the balance, the balance is my responsibility and payment is due in full.
- I understand that if my first visit is an emergency visit, I will be responsible for payment of services in full at the time of the visit. As a courtesy, Simply Children's Dentistry, Inc. will provide to me the necessary documents to file to my insurance company for reimbursement.

For patients with insurance, please initial the billing option of your choice:

____ I will pay my total balance at the time of service and will seek reimbursement directly from my insurance company.

____ I will pay only my estimated portion at time of service and have my insurance pay the office. If my insurance company fails to pay the balance, it remains my responsibility and I must pay all amounts due. If this is my first and it is an emergency visit, I understand that payment for all services is due at the time of treatment.

I have read, understand and agree to the above Office Financial Policy.

____ ______________________________

Signature of Patient/Guardian Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____________________

Address: ____________________

Telephone: ____________________ Email: ____________________

Patient Number: ____________________ Social Security Number: ____________________

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. We encourage you to read if carefully and completely and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contracting:

Contact Person: ____________________

Telephone: ____________________ **Fax:** ____________________

Email: ____________________

Address: ____________________

SIGNATURE

I, ____________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected heath information to carry out treatment, payment activities and healthcare operations.

Signature: ____________________ Date: ____________________

If this Consent is signed by a representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________

Relationship to Patient: ____________________

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I have the right to revoke this Consent at any time by giving Simply Children's Dentistry, Inc. written notice of my revocation submitted to the Contact Person listed above. I understand that revocation of this Consent will *not* affect any action the office took in reliance on this Consent before they received my revocation, and that Simply Children's Dentistry, Inc. may decline to treat me or to continue treating me if I revoke this consent.

Signature: ____________________ Date: ____________________