ALL SMILES FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices (SPP) for the office of All Smiles Family Dentistry. This document describes the types and uses of disclosures of my Protected Health Information (PHI) that might occur in my treatment, payment for services, or in the performance of office health care operations. This document also describes my rights and the responsibilities and duties of the office with respect to my PHI. The SPP is also posted in the facility. All Smiles Family Dentistry reserves the right to change the privacy practices currently described in the document. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised copy by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

I hereby specifically authorize disclosure of my PHI to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected PHI cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only Yes _____ No _____
OR
Any Member of my immediate family (Spouse, Children, Children's Spouses) Yes _____ No _____
Any Member of my extended family (Parents, Grandchildren) Yes _____ No _____

Name of Patient (print) _____ Signature _____
If patient under 18 years of age please fill out the following:
Parent/ Guardian name (print) _____ Signature _____
Telephone number _____Email: _____Date_____

FINANCIAL POLICY AND PATIENT OPTIONS

We Accept: Cash, Check, Credit, Debit

Patients Who Have Dental Insurance: Insurance estimate is NOT a guarantee of payment, we do a courtesy check for you. Whatever insurance does not pay is your responsibility.

All Smiles Payment Plan: In-house financing, interest-free! Up to 6 payments. No credit check done.

Care Credit: Up to 12 month financing. Requires approval/credit check. Please ask for details.

Canceling or Re-scheduling Appointment: We request 48 hour notice to accommodate other patients .

Missed Appointment: Failing to show-up or calling less than 24 hours in advance may incur $50 fee.

Referrals: $25 credit! The greatest compliment you can give us is to refer a family, friend or colleague.

The signature below indicates that I have read & agree to the terms & sections detailed in this form.

Signature _____ Print_____Date_____