Optima Family Dental

Dear Patient:

Our office is most happy to complete and submit most insurance claim forms. We accept both managed care and standard insurance plans. Please keep in mind that most insurance companies **do not cover al**l dental expenses. We encourage you to discuss any questions you may have regarding your specific plan with our office management and insurance department staff. Questions regarding your dental care should be discussed with your doctor. Thank you for the opportunity to serve you.

Please read and sign below showing you understand the following:

- I understand that my insurance policy may/may not cover all dental services and that it is my responsibility to call my insurance company to verify my/my family's coverage on dental procedures to be performed on me/my family.
- My insurance plan may have a deductible and/or co-payment amount which is due at the time of service. I understand that I will be responsible for any other balance **not** paid by my insurance company.
- Any Flex Plan reimbursement will be paid directly to me upon submission of my **paid** receipts to my company.
- I accept full responsibility for all fees required for my child's/children's dentistry regardless of my marital status.
- I understand there is a charge for failing an appointment or canceling without 24 hours notice.
- In the event that I/my family want to transfer to another office, I understand that my/my family's balance must be paid in full to receive copies of dental records. There is a charge for duplication of x-rays at the request of me or my insurance company.
- I understand that if my check payment is returned NSF from the bank, there is a $25.00 NSF charge which will be added to my account, and I may be asked to make payment by credit card, money order, or cash only.
- I understand that I am responsible for any reasonable fees, expenses, or costs related to the collection of any unpaid balance, including but not limited to late charges, referral costs, and commissions paid to attorneys or collection agencies.

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Signature *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, Which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

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Please Print your name here *Date*

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Signature *Date*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

□ The patient refused to sign.
□ Due to an emergency situation it was not possible to obtain an acknowledgement.
□ We weren't able to communicate with the patient.
□ Other (Please provide specific details)

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Employee Signature *Date*

HIPPA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state law.