

Notice of Privacy Practices

I, _____ have received and have been given the opportunity to review the *Notice of Privacy Practices*.

You may disclose my dental diagnoses/conditions to the following person(s).

You may leave messages on my home phone regarding the following:

___Appt time/Dentist's Name/Pre-med Reminder ___Confidential information (x-ray results, etc.)

Financial Responsibility

Payment (cash, credit/debit card, check, money order) is due at the time of dental services. We will submit a claim to your insurance company if you provide us with complete and accurate information at the time of your visit. It is your responsibility to know which services your insurance covers and at what percentage they pay for those services. You will be required to pay the difference in full.

Accounts have a 90-day "grace period," after which the unpaid balance will be charged 18% interest per annum. In the event of arbitration, the non-prevailing party will be responsible to pay all costs of arbitration, the prevailing party's reasonable attorney's fees and costs, plus legal interest.

Returned checks will be assessed a \$25.00 NSF fee, as allowed by Oregon law.

If you are more than 10 minutes late to your appointment, you may need to reschedule. In order to avoid a \$25.00 "no show" fee, if you are unable to keep an appointment, please notify us at least 24 hours in advance.

Patient Name _____ DOB _____

Responsible Party:

Name (if different from above) _____ DOB _____

Mailing Address _____

Phone Number _____

Insurance Company _____

Employer (if group insurance) _____

S.S.# (required for insurance claim submission) _____

Signature _____ Date _____