Island City Dental

PATIENT RELEASE/HIPAA/FINANCIAL POLICY

Patient Name(_____)

Thank you for the confidence you have shown in choosing us to provide for your dental needs. We are pleased to assist with your insurance (if applicable); however, you are ultimately responsible for payment of your bill.

1. AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of my Protected Health Information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails without special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below-named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

_____Please Circle: Spouse Parent Child Other

Signature of Patient/Legal Guardian: _____Date: _____

2. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that the Notice of Privacy Practices is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the Notice and one will be provided to me.

Signature of Patient/Legal Guardian: _____Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but this could not be obtained because:

- ___ *Individual refused to sign*
- ___ *Communications barriers prohibited obtaining the acknowledgement*
- ___ *an emergency situation prevented us from obtaining the acknowledgment*
- ___ *Other:*

Employee Signature: _____ Date_____

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3. FINANCIAL RESPONSIBILITY: I understand I am personally responsible for any fees I incur for services rendered. I acknowledge I am responsible for any charges incurred by not providing the most current, correct insurance at time of service. Finance charges may be assessed against overdue accounts. In the event any fees are unpaid and it becomes necessary to pursue collection efforts, I agree to pay all costs directly associated with such collection efforts. I acknowledge any demographic information provided by me, including my cellular phone number, may be used to contact me for any purpose, including collection efforts.

I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to Island City Dental.

Signature of Patient/Legal Guardian: _____Date: _____