PRIVACY PRACTICES & FINANCIAL POLICY
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
(Must be signed by ALL new patients)

By signing below, I acknowledge that I have read and understand All Smiles Dental Care's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the amended modifications of 2002, 2013 and state law. I further understand that a copy can be provided to me upon my request.

Patient/Legal Guardian's Signature ____ **Date** __________________

AUTHORIZATION FOR ADDITIONAL DISCLOSURE
(Necessary if you wish us to be able to share your health information with other individuals, such as family or friends)

I authorize the following individuals to have access to my health information. I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released. I may revoke this authorization by notifying All Smiles Dental Care in writing.

	Name	Relationship
1.	____	______________________________
2.	____	______________________________

Patient/Legal Guardian's Signature ____ **Date** __________________

PAYMENT, CANCELLATION AND FINANCIAL POLICY
(Must be signed by ALL new patients)

By signing below, I acknowledge that payment is due in full at the time of treatment, unless prior arrangements have been approved. If using dental insurance, please be aware the information provided by your insurance company is limited and is not a guarantee of coverage. We anticipate payment from insurance companies within 6 weeks of the date of service. After that time, any balance owed will be your responsibility and reimbursement can be sought from the insurance company. Regardless of insurance coverage, or anticipated benefit, you are responsible for payment for all services rendered.

For balances not paid in full, after 30 days a late fee of 1.5% (18% per annum) may be charged on a monthly basis until the balance is paid. Check payments are accepted, however if returned for insufficient funds, a $30 returned check fee will be charged.

We want to avoid any possibility of collections for your account, but in the event your account becomes delinquent, we reserve the right to place your account in the hands of an attorney or collection agency. If this occurs, you will be responsible to pay any collection costs and/or attorney fees, which typically range from 30% to 50% of the unpaid balance.

We strive to serve our patients in a timely manner and respect your busy lives, so please return the favor and respect our schedule. We ask that if you need to cancel your appointment, that you give us a **48 business hour notice**; otherwise, we will charge a **$25 cancellation fee.** We understand that emergencies and illness can occur; therefore, we just ask that you contact our office to let us know your circumstances.

Patient/Legal Guardian's Signature ____ **Date** __________________