NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third party payers

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Office policy of Westford Family Dental

Financial agreement: Payment is due at the time of service (Financial assistance is available upon credit approval). There will be a $25 charge for any returned checks.

Balance left on account for more than 60 days: All parties will be responsible for the cost of collections, which may include but is not limited to any and all collection and legal fees.

Cancellation and failure to arrive: We understand that circumstances do arise that can keep you from a dental appointment. Please have the courtesy to give the office 24 hour notice. *There will be a $25 missed appointment charge.*

X-rays: Original x-rays are the property of Westford Family Dental. We will provide you with a duplicate copy for a $25 charge. Please give the office a 72 hour notice before picking up or mailing out.

Attention Insured Patients

As a courtesy we will submit all charges to the insurance company. Insurance is designated to cover a portion of the customary fee. Co-payments are collected at the time of service. To submit claims accurately, we need all the necessary information on the policy holder.

Note: Insurance provided by the insurance company **IS NOT A GUARANTEE OF BENEFITS,** only an **ESTIMATE.** Please review your policy books so there are no misunderstandings. If you do not have a book, contact your human resource office.

Until the insurance company receives the claim, it is still an estimate and not a guarantee.

You the patient are responsible for your own policy, **WE ARE THIRD PARTY BILLING ONLY,** and given minimal information by your insurance company. We send in estimates for you so that we have in writing, please do not ask the front desk to do so.

PLEASE SIGN BELOW

- I authorize direct payments of benefits to Westford Family Dental, for treatment rendered to myself and/or my family.
- I have read and understood the above policies, and have asked all pertinent questions.

Patient signature: _____ **Date:** _____
(or parent/legal guardian if minor)

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