HIPPA Privacy Practices

I have received and/or read either a paper or electronic copy of the HIPPA Notices of Privacy Practices from O'Brien Smiles. I understand that I am entitled to a copy if requested.

_____ **Initials**

Permission to Discuss Treatment and/or Billing Information

I give permission to discuss any and all health, treatment, or billing information with:

_____

Name

_____

Relationship to Patient

_____ **Initials**

Appointment Reminders

We will remind you of upcoming appointments by using text and email messages. Please make sure we have your current cell phone number and email address:

_____

Email address

_____

Cell phone

Financial / Insurance Policy

Payment is due at the time service is rendered. Our office accepts Cash, Check, Major Credit Cards, and Care Credit.

As a courtesy to our patients with Dental Insurance, we will gladly submit your claim. It is the patient's responsibility to know your dental benefits. Your Dental Insurance is a contract between you and your insurance company. We will always help patients maximize their dental benefits.

_____ **Initials**

Scheduling Policy

A **48 hours** notice is required to make any changes in the Doctor or Hygiene schedule. Any changes in the schedule made without proper notification will result in a cancelation fee of **$75.00 per hour reserved.**

_____ **Initials**

I acknowledge that I have read, understand, and accept the above office policies.

_____

Name

_____

Date