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

ALLISON O'BRIEN
DMD

Dental Health and Wellness
Allison O'Brien DMD
8936 77th Terrace East, Suite 103
Lakewood Ranch, FL 34202

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 t is the patient's responsibility to know your dental benefits. Your Dental Insurance is a contract between you and your insurance company. We allow **45 days** from the date the claim was filed for the insurance company to pay on your claim. In the event that payment has not been received, you are responsible for the full amount of services rendered.

A **$35** fee will be assessed on any returned check.

_____ **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**

Please Sign & Date Below

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

_____

Name

_____

Date