
# Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will submit patient's insurance forms as a courtesy.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. **I further agree to pay all costs incurred by a collection agency or any possible attorney's fees due to nonpayment.** I grant my permission to you or your assignee, to email or telephone me to discuss this statement or my treatment.

**Missed/Canceled appointment policy:** When an appointment is missed or cancelled less than 24 hours, a $75 fee may be charged.

# HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize Boenning & Dancykier DDS, LLC to release my personal/dental information to the following individual(s):

Please enter name and relationship to patient.

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*By signing below, I understand the above information and agree with its contents, and this will serve as my signature for the HIPAA Disclosure Form and Consent for Services and Financial Policy.

**NAME**: _____

**DATE**: _____