Authorization Form for Use or Disclosure of Patient Protected Health Information (PHI)

Patient Name: _____

Patient's Date of Birth: _____

I, _____ hereby authorize David W. Hammer DMD and office representatives to release the following Protected Health Information (PHI):

□ Billing Information □ Appointment Information

□ Clinical Information □ **ALL**

□ Insurance Information

The following person(s) may receive this information:

_____

_____

_____

□ I do not authorize David W. Hammer DMD and office representatives to release any of my Protected Health Information (PHI) to anyone.

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice.

Signature: _____ Date: _____

ACKNOWLEDGEMENT FORMS

Stony Spring Family Dental Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all services rendered.

Missed Appointments:
Unless we receive notice of cancellation 24 hours in advance, you will be charged $75.00. Please help us serve you better by keeping scheduled appointments.

Insurance:
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to the contract. As a courtesy to you, our office provides certain services, including pre-treatment estimates which we send to the insurance company at your request. It is impossible for us to have knowledge and keep track of every aspect of your insurance. **It is up to you to contact your insurance company and inquire as to what your benefits are.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.
Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Payment:
FULL PAYMENT is due at the time of service; unless otherwise discussed. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service.
Please indicate below the form of payment you wish to use:

- □ Check
- □ Visa, MasterCard or Discover
- □ Care Credit

Unpaid balances 60 days past treatment date will be subject to a $3.50 billing fee each month until balance is paid in full. If payment is delinquent, the patient will be responsible for payment of collections, attorney's fees and court costs associated with the recovery of the monies due on the account.
I have read, understand and agree to the terms and conditions of this Financial Agreement.

Signature: _____ Date: _____

ACKNOWLEDGEMENT FORMS

Stony Spring Family Dental
Missed Appointment and Cancellation Policy

We ask that you make every effort to give us **at least a 24-hour advanced notice** if you cannot make your scheduled appointment. It is our policy to charge any patient a $75.00 fee for a cancelled or missed appointment.

To cancel an appointment, you must call the office at 502-499-8827. You cannot cancel or reschedule appointments via email.

Signature: _____ Date: _____