Notice of Privacy Practices

I, _____ have received and have been given the opportunity to review the *Notice of Privacy Practices*.

You may disclose my dental diagnoses/conditions to the following person(s).

_____

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_____

_ You may leave messages on my home phone regarding the following:

____Appt time/Dentist's Name/Pre-med Reminder ____Confidential information (x-ray results, etc.)

Financial Responsibility

Payment (cash, credit/debit card, check, money order) is due at the time of dental services. We will submit a claim to your insurance company if you provide us with complete and accurate information at the time of your visit. It is your responsibility to know which services your insurance covers and at what percentage they pay for those services. You will be required to pay the difference in full.

Accounts have a 90-day "grace period," after which the unpaid balance will be charged 18% interest per annum. In the event of arbitration, the non-prevailing party will be responsible to pay all costs of arbitration, the prevailing party's reasonable attorney's fees and costs, plus legal interest.

Returned checks will be assessed a $25.00 NSF fee, as allowed by Oregon law.

If you are more than 10 minutes late to your appointment, you will be rescheduled and a $50 no show fee will be added to your account. If you are unable to keep an appointment, please notify us at least 48 hours in advance to avoid the $50 no show fee.

Patient Name_____ DOB _____

Responsible Party:

Name (if different from above). _____ DOB_____

Mailing Address _____

Phone Number_____

Insurance Company_____

Employer (if group insurance) _____

S.S.# (required for insurance claim submission). _____

Signature _____ Date_____