SHELDON FAMILY DENTAL

ACKNOWLEDGEMENT & CONSENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFURE TO SIGN THIS ACKNOWLEDGEMENT

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

I, (Patients' Name) _____, have been offered a copy of and understand the scope of this office's Notice of Privacy Practices. I consent my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature _____ (type name if filling electronically)

Date_____

INSURANCE AND FINANCIAL RESPONSIBILITY

I am responsible for the payment of the treatment that I receive at each visit. If I have dental insurance I will disclose all necessary. Information and I will be responsible for any balance(s) that will remain from my insurance. It should be understood, that the dental insurance contract is between the insurance company and the patient, whom bears the ultimate financial responsibility.

X _____(type)_____ Date _____

FOR OFFICE USE ONLY:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

SHELDON FAMILY DENTAL

OFFICE POLICIES AND FINANCIAL AGREEMENT

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for that oral health along with providing each patient with the highest quality of dental care. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

Regarding Insurance

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice and patient to coordinate with insurance companies. There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and maximum. These changes do not get shared with us. Therefore, it is impossible for us to know exactly what your policy covers. It is your responsibility as a patient to know what your benefits, deductibles and maximum are throughout your policy year so that you may make informed decisions on any appointments made.

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you and maximizing your benefits. However, we are unable to carry your insurance balance for longer than 90 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of your visit.

In certain cases, the use of upgraded materials and procedures that are not covered by your insurance policy may be prescribed by the doctor. Some of which are not covered by your insurance policy and will not be submitted for reimbursement. By signing this agreement, you are consenting to the use of such materials and procedures.

Payment Options

Your options include Cash, Check, MasterCard, Visa, Discover and American Express. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through CareCredit, our financial partner. If you would like to use CareCredit to assist you with your treatment needs, please see the front desk for more information. You can also apply for CareCredit directly online through their website.

Additional Charges

A fee of $45.00 will be charged for all returned checks.

Delinquent Accounts

After 90 days, all accounts that are not paid in full may be sent to a third party collection agency.

Cancellation Policy

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two-business days' notice. All changes in your scheduled appointment must be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient.

I have read, understand and agree to the above Office Policies and Financial Agreement

_____(type)_ Date _____

Patient Signature
(Parent/Guarantor signature if the patient is a MINOR)

Child's Name _____

☐ By checking this box, I acknowledge the use of my electronic signature