HIPPA - Consent Form, Office Appointment/Financial Policies & Records Release

Your signature acknowledges your understanding and acceptance of the following:

- ***48 Hour Cancellation Policy*** - In order to avoid missed appointment cancellation fees ($50/½ hour) please provide us with two business days notice. This will allow us to fill the doctor's schedule.
- ***Co-payment due when services are rendered***- All known or estimated co-payments are due when services are rendered. We will provide you with an estimate of your co-payment prior to or during your visit.
- ***Late Fees and Interest Charge***s- As a courtesy our office will process insurance claims for you if we are contracted with your insurance provider. Any claims outstanding after 90 days will become patients' responsibility and full balance is due to the office. All balances older than 90 days will incur an annual interest rate of 22%. Accounts with missed payments will incur a $10 late fee. Any unpaid balances after 60 days will be submitted to American Agency.
- ***Insurance and Contact Information*** - You are responsible for updating our office with any changes to your insurance coverage and or personal information including work performed at other offices, phone number/ address, job changes, etc.
- ***Co-pay Write-off*** – Per our contract with your insurance company we cannot write-off your co-payments. Please discuss any finance concerns with our team. We have interest and interest free (if qualified) payment plans available.

Your signature acknowledges receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment, and Operations:

By signing below, I hereby acknowledge that I have been provided with a copy (take-home copy by request) of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the notice.

Your signature acknowledges your granting medical records release permission

By signing below I grant Roos Dental Care permission to transfer my x-rays and medical treatment summary to licensed medical professionals for purposes of my dental/medical treatment now and in the future at my request or per Roos Dental Care's referral (to specialists, other doctors etc.)

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Signature - Patient/Personal Representative/Legal Guardian Today's Date

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Print Name and relationship to patient