Hillcrest Family Dental

Patient Release/HIPAA/Financial Policy

Patient Name_____

Thank you for the confidence you have shown in choosing us to provide for your dental needs. We are pleased to assist with your insurance (if applicable); however, you are ultimately responsible for payment of your bill.

1. **Authorization to release information**: I hereby authorize the release of my protected health information (PHI) acquired in the course of my examination or treatment (typically x-rays, but could include health history, diagnosis, treatment or payment records), via electronic transmission, including emails without special encryption, to my insurance company to secure payment for services or to other dental providers required to participate in my care. I further authorize the below-named parties have access to my PHI and do acknowledge any party providing insurance coverage or financial responsibility will have access to my PHI.

   _____Please circle: Spouse Parent Child Other

   Signature of patient/legal guardian _____ Date_____

2. **Acknowledgement of receipt of notice of privacy practices**: I acknowledge that the notice of privacy practice is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

   Signature of Patient /Legal guardian _____ Date _____

3. **Financial responsibility:** I understand I am personally responsible for any fees I incur for services rendered. I acknowledge I am responsible for any charges incurred by not providing the most current, correct insurance at time of service. Finance charges may be assessed against overdue accounts. In the event any fees are unpaid and it becomes necessary to acknowledge any demographic information provided by me, including cellular phone number, may be used to contact me for any purpose, including collection efforts.
   I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to Hillcrest Family Dental.

   Signature of Patient/Legal guardian _____ Date _____

For office use only

We attempted to obtain written acknowledgement of receipt of our notice of privacy practices, but his could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining the acknowledgment
_____ Other: _____

Employee signature ____ Date ________________