

ACKNOWLEDGMENT OF OFFICE POLICIES

Patient's Name: _____ Date: _____

Parent / Guardian's Name: _____
(if applicable)

NOTICE OF PRIVACY PRACTICES

I have read a copy of Main St. Dental's Notice of Privacy Practices, which explains how my personal information will be used and disclosed. I further authorize the release of any information necessary to process insurance claims on my behalf.

Patient Signature (or parent/guardian) _____

PAYMENT POLICIES

Our office staff "understands" dental insurance, and we will be glad to assist you in obtaining the maximum benefits specified in your contract.

You must realize however, that:

1. Your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally, but not necessarily, covered in full by the maximum allowance determined by your carrier.
3. Not all dental services are a covered benefit in all contracts.
4. We will bill your insurance company; although, you are responsible to us for all our fees for services rendered to you.

Any of us will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care.

I UNDERSTAND THE ABOVE AND WILL BE RESPONSIBLE FOR THE TOTAL FEES.

Patient Signature (or parent/guardian) _____

CANCELLATION POLICY

Your appointment time is reserved exclusively for you. Due to the limited availability of appointment times, we require 48 hours notice for any appointment change in order to avoid a **\$50 broken appointment fee**. Thank you for your understanding and cooperation in this matter.

I agree to abide by the office policy of Dr. Carol Evans.

Patient Signature (or parent/guardian) _____