Notice of Privacy Policies

Name:
DOB (Date of Birth):
Date:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices given to me by Tusk Dental Co. I have had the opportunity to ask any and all questions. I understand that I am giving my permission to the use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Parent/Guardian Name: _____

Relationship to Patient: _____

Patient/Guardian Signature: _____

Office Agreement & Consent Forms

We accept Cash, Check, Visa, MasterCard, Discover, American Express and CareCredit cards.

An appointment reservation deposit of $ _____ (regardless of insurance benefits) is required when scheduling an appointment for major services. This deposit is non-refundable at the discretion of Tusk Dental Co.

Dental Insurance: We will be happy to submit an insurance claim for you as a courtesy. Most insurance claims automatically file electronically. It is your responsibility to inform us of any changes in your insurance carrier or policy. If your insurance company denies your claim, we expect payment of the full balance within 10 days of the notice you receive from your insurance company. Professional services are rendered to a person, not to the insurance company. Our treatment is based on the dental need of the patient, not the insurance company benefits. We cannot render services to a patient on the assumption that the charges will be paid by the insurance company, nor can we know every service not covered by your insurance company. We will help in any way possible to file your claim or handle any insurance queries you may have. It is your responsibility to be involved with your insurance company. The patient is responsible to the doctor and the insurance company is responsible to the patient.

Saturday Appointments: A credit card is required to schedule an appointment on a Saturday. We will keep the credit card on file, and it will only be charged if the appointment is missed or cancelled/rescheduled within 48 hours, at the discretion of Tusk Dental Co.

Returned Checks: There is a $35.00 handling fee for any returned check.

Missed Appointments: No Charge will be made for rescheduling an appointment provided a 48 hour notice has been given; otherwise, a minimum charge of $100.00 per half hour of the missed appointment will be posted on the account. Please remember that this time has been reserved specifically for you.

Attorney and/or Collection Fees: Any fee incurred in collection of a delinquent account will be charged to the patient's account. We are here to help no question is too small for you to ask. Please feel free to call when you have a question. Thank you for your loyalty and for your referrals of your friends and family.

I_____ authorize the release of any information and/or x-rays relating to my dental treatment to the insurance company, attorney, or collection agency in collecting the full cost of the services provided for myself and my family. I agree to accept the standard fees of this office regardless of my insurance benefit agreement and I understand that there may be a difference in the insurance plan fee and the standard fee. I take responsibility for the entire fee charged. I understand that this office expects that I pay in full for the services as they are provided. If I do not

hear from my insurance company within 60 days, I will contact the office manager at Tusk Dental Co. and inform the situation.

I _____ authorize the release of any information and/or x-rays to dental offices where I have been referred. I have received a copy of this office's Notice of Privacy Practices. Consent: The undersigned hereby authorizes the Dentist at Tusk Dental Co. to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs.

I_____ authorize the doctor to perform all forms of treatment, medication, and therapy, that may be indicated in connection with the patient and further authorize and consent that the doctor chooses and employ such assistance as deemed fit. I understand the use of anesthetic agents embodies a certain risk.

I_____ authorize Tusk Dental Co. to send text messages regarding appointment and scheduling. Personal contact number will not be shared with any third party vendors.

Name (Printed): _____ Date: _____

Signature: _____

Financial Agreement

Name:
DOB (Date of Birth):
Date:

- For my convenience, this office may release my information to my insurance company and receive payment directly from them.
- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- I will pay a fee for appointments broken without 24 hours' notice.
- Treatment plans may change, and I will be responsible for the work done.
- I agree to let this office run a credit report. If no, then all fees are due at time of service.

☐ Yes
☐ No

Parent/Guardian Name (If patient is minor): _____

Relation of patient: _____

Patient/Guardian Signature: _____