ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Kasey Davis Dentistry

589 A Shades Crest Road

Hoover, AL 35226

205-822-7277

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Kasey Davis Dentistry's *HIPAA Notice of Privacy Practices*.

I understand that Kasey Davis Dentistry's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Kasey Davis Dentistry's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Kasey Davis Dentistry's *HIPAA Notice of Privacy Practices*, I may contact Kasey Davis at 205-822-7277.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Kasey Davis Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Kasey Davis Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Kasey Davis, noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
	_____
	Relationship of Personal Representative to Patient

KASEY DAVIS DENTISTRY

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: ☐ Male ☐ Female Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Local Paper	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Home #: _____ Work #: _____ Mobile #: _____

KASEY DAVIS DENTISTRY

Insurance Information (Primary)

Name of Policy Holder: _____ Relationship to patient: _____

Subscriber Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Claims Address _____

Employer Name: _____ Phone: _____

Group #: _____ ID #: _____

****FOR OFFICE USE:** *Individual Deductible*: $ _____/$ _____Met; *Maximum*: $ _____/$ _____Met**

Insurance Information (Secondary)

Name of Policy Holder: _____ Relationship to patient: _____

Subscriber Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Claims Address _____

Group #: _____ ID #: _____

Employer Name: _____ Phone: _____

****FOR OFFICE USE:** *Individual Deductible*: $ _____/$ _____Met; *Maximum*: $ _____/$ _____Met**

Cancellations and Missed Appointments

We require 48 hours advance notice of a cancellation. Patients who do not provide 48 hours notice of a cancellation or who do not present for a scheduled appointment may be charged a fee. After the first missed appointment, we will waive the broken appointment fee as a ONE TIME courtesy. Patients who fail to present for a second appointment will be charged a $30 fee, a statement and a letter will be mailed reiterating our policy and reminding the patient of the risk of dismissal should another appointment be missed.

I have read the Cancellation and Missed Appointment Policy. I understand and agree to this Policy.

Patient Signature_____Date_____

589-A Shades Crest Road
Hoover, Alabama 35226
(205) 822-7277

OFFICE FINANCIAL POLICY

Financial Arrangements
Because you are a valued patient of Kasey Davis Dentistry, we want to inform you of our payment expectations and the financial arrangements available at our office.

Our Philosophy
Kasey Davis Dentistry is committed to providing you with the best possible dental care available today. Prior to starting treatment, we will provide you with an estimate of your treatment costs and answer any questions you may have. We prefer that payment be made the same day treatment is rendered. If financial arrangements are desired to enable you to receive and pay for quality dental care, we will be happy to discuss payment options with you.

Insurance
Dental insurance plans are welcome. If you have dental insurance, we will make every reasonable effort to help you maximize the dental benefits that you have already paid for. Our business staff will be glad to assist you in receiving your dental benefits, so always bring your insurance information with you. *Please recognize however that the insurance agreement is between you and your employer or the healthcare exchange. The final responsibility for payment is yours.*

Payment Options
Payment is due at the time of service. We accept:
-Cash
-Personal Check
-MasterCard
-Visa
-Discover
-American Express
For payments in full that are paid for on the date of service for treatment plans greater than $150, we will offer a five percent (5%) reduction of the total fee if payment is made by cash or check.

Financing Options
Kasey Davis Dentistry wants to make paying for dental care as easy as possible. If you would like to pay your balance over time, we offer third party financing choices, for qualified applicants. The options offer flexible, monthly payment plans that can be used immediately. *Please ask us about our in-house financing options if you are unable to qualify for fixed monthly payments through a third party creditor. Kasey Davis Dentistry will allow in-house financing on certain procedures, under certain circumstances on a case-by-case review*. For a fixed monthly payment with deferred or no-interest options up to twelve months for qualified patients, our practice does accept **CareCredit**™. If you are interested in learning more about either of the above options, just let us know and we'll be happy to assist you.

If You Have Insurance

Our goal is to help you maximize your dental insurance benefits. We emphasize as dental care providers that our relationship is with you, and not your insurance company. While filing insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date the services are rendered.

Our business staff is available Tuesday-Friday 8:00AM-4:00PM to discuss your estimated insurance coverage, annual maximum, deductible and make financial arrangements if desired. If your dental plan does not pay Kasey Davis Dentistry within 60 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check. Also, remember that dental insurance plans are not designed to cover all your dental needs. Rather, the amount your dental plan contributed towards your dental care is based on the plan selected and purchased by the individual or by your employer.

Treatment Estimates

All estimates for planned treatment and care are just that, estimates. Please understand that should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment.

Payment Delinquencies

All monthly statements are due and payable in full upon receipt unless prior financial arrangements have been made. We accept cash, checks, and all major credit cards. Before being turned over to our collection agency and the credit bureau, our office will notify you by letter of final notice to pay. Patients with delinquent accounts *of 60+ days* that have been otherwise notified are liable for all costs incurred for collection of past due balances, included collection agency fee (*33*%), attorney fees, court fees, and all costs involved in litigation.

Returned Checks

Any check that is made payable to our office that is not cleared through the bank and is returned to our office due to insufficient funds will be returned to the patient and the patient will be responsible for a $*15.00* fee. No future payments by check will therefore be accepted.

Effective: September 1, 2017

_____ _____

Signature of Financially Responsible DATE

*****CONTINUE BELOW IF RESPONSIBLE PARTY IS NOT THE PATIENT*****

_____ _____

Responsible Party Name & Relationship to Patient (*Please print*) DATE

Do you have Power of Attorney? Y / N *(Please circle and give a copy of paperwork to our staff to place on file.)*