Garden Gate
DENTAL

Acknowledgment of Notice of Privacy Practices

I, _____ have been given the opportunity to review this office's Notice of Privacy Practices.

_____

(Signature)

_____

(Date)

Consent for use and disclosure of health information:

Purpose of Consent: By signing this portion of the form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Dr. Tyson Roe, DDS PA
6004 Creedmoor Rd. Raleigh, NC 27612
919-787-8770

Financial Policy

In order to deliver comprehensive quality dental care for our patients at reasonable fees, it is important to control costs. Since it is unfair to pass the additional costs of carrying and collecting overdue or delinquent accounts of a few to all of our patients in the form of increased fees, we ask each patient to accept financial responsibility for the fees involved in their dental treatment, as we accept professional responsibility for providing that care.

We trust that you understand and appreciate the need for a clear policy regarding your account. We ask you to please read the financial information and sign at the end. Please feel free to ask any questions of our staff.

You are asked to settle all accounts at the time of service. Special payment arrangements are available upon request if made in advance of the appointment. If you believe there are mistakes concerning your account, please contact us by phone during business hours. If we do not hear from you, we assume everything is correct with your account. For your convenience we accept cash, check, Visa, MasterCard, Discover, American Express and bank financing upon credit approval. Professional services are rendered and charged to the patient and not to the Insurance Company, we will always be happy to assist you with your insurance.

All account are covered under the following provisions:

1. We ask that you pay us and have your insurance company reimburse you. We will give you an itemized copy of your charges for the visit.

2. Any accounts remaining unpaid over sixty (60) days will incur finance charges at 1.5% per month and are delinquent.

3. All returned checks are assessed a $25.00 charge. Since your bank must, by law, inform you of a non-sufficient funds check, we expect you to contact us to make arrangements for settling the full amount of the check plus $25.00, within five (5) days. All other policy provisions as noted above apply.

4. Any account requiring legal assistance for collecting will have all legal fees, collection and court costs added to the unpaid balance.

We thank you for your cooperation and look forward to providing dental care for you and your family with a clear understanding of each party's responsibilities.

DR ROE AND STAFF

I read and fully understand the above Financial Policy.

Signature: _____ Date: _____