# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third party payers

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

# Office policy of Tyngsboro Dental Care

**Financial agreement:** Payment is due at the time of service (Financial assistance is available upon credit approval). There will be a $25 charge for any returned checks.

**Balance left on account for more than 60 days:** All parties will be responsible for the cost of collections, which may include but is not limited to any and all collection and legal fees.

**Cancellation and failure to arrive:** We understand that circumstances do arise that can keep you from a dental appointment. Please have the courtesy to give the office 24 hour notice. *There will be a $25 missed appointment charge.*

**X-rays:** Original x-rays are the property of Tyngsboro Dental Care. We will provide you with a duplicate copy for a $25 charge. Please give the office a 72 hour notice before picking up or mailing out.

## Attention Insured Patients

As a courtesy we will submit all charges to the insurance company. Insurance is designated to cover a portion of the customary fee. Co-payments are collected at the time of service. To submit claims accurately, we need all the necessary information on the policy holder.

**Note:** Insurance provided by the insurance company **IS NOT A GUARANTEE OF BENEFITS,** only an **ESTIMATE.** Please review your policy books so there are no misunderstandings. If you do not have a book, contact your human resource office.

Until the insurance company receives the claim, it is still an estimate and not a guarantee.

You the patient are responsible for your own policy, **WE ARE THIRD PARTY BILLING ONLY,** and given minimal information by your insurance company. We send in estimates for you so that we have in writing, please do not ask the front desk to do so.

**PLEASE SIGN BELOW**

- I authorize direct payments of benefits to Tyngsboro Dental Care, for treatment rendered to myself and/or my family.
- I have read and understood the above policies, and have asked all pertinent questions.

**Patient signature:** _____ **Date:** _____
(or parent/legal guardian if minor)

Tyngsboro Dental Care PC, 150 Westford Rd, #3, Tyngsborough, MA 01879. Ph: 978-259-5965