

Superstition Mountain Dental
5331 S. Superstition Mountain Drive
Gold Canyon, AZ 85218

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ have received a copy or reviewed a copy of this office's Notice of Privacy Practices.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual Refused to Sign.
- Communication barriers prohibit obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Superstition Mountain Dental

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship.

1. Payment is due at the time services are rendered, including co-payments.
2. If insurance is involved, co-payment and any deductible are to be paid in full at the time services are rendered.
3. If your insurance company denies payment for any reason, you will be responsible for the entire account balance.
4. You may use cash, check, Visa, MasterCard, Discover, or American Express as your method of payment.
5. In the event that your account is referred for collection, a 30% collection service fee will be added to your account balance. In addition, you will be responsible for all fees incurred or associated with collection on your account.
6. There will be a **\$25.00 fee** when we are not given at least **24 hour notice** for broken appointments.

IT IS THE PATIENTS RESPONSIBILITY TO PAY THE REMAINING BALANCE THAT IS NOT COVERED BY INSURANCE.

If care is being rendered on a minor child, the parent or guardian who accompanies the child to the appointment is financially responsible for the account.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT REGARDLESS OF WHAT MY INSURANCE CARRIER MAY OR MAY NOT COVER. THIS SIGNATURE WILL ALSO SERVE AS "SIGNATURE ON FILE" FOR ASSIGNMENT OF INSURANCE BENEFITS.

PATIENT SIGNATURE: _____ DATE _____