Acknowledgement of Responsible Party

PATIENT NAME: ____

I acknowledge that a copy of Tower Dental Notice of Privacy Practices is available to me.

( ) I am requesting a copy of Tower Dental Notice of Privacy Practices ________ Initial

( ) I decline to receive a copy of Tower Dental Notice of Privacy Practices ________ Initial

I also understand payment is due at the time of treatment unless prior arrangements have been approved.

Tower Dental submits claims to various insurance companies and I understand that I am responsible for all costs of dental treatment and payment for services rendered. I understand that I am responsible for any patient portion including deductibles that insurance does not cover. I understand that estimates provided to me are not a guarantee of any insurance payment that may or may not be payable by insurance. I hereby authorize my insurance company to make insurance payment directly to Tower Dental. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information including diagnosis and records of treatment or examination rendered to my insurance company.

I UNDERSTAND THAT TOWER DENTAL HAS A 24-BUSINESS HOUR CANCELLATION POLICY. IF AN APPOINTMENT IS MISSED, CANCELLED RESCHEDULED WITHOUT A 24-BUSINESS HOUR NOTICE THERE WILL BE A FEE INCURRED.

______________________________ ______________________________
Signature of Responsible Party Date

______________________________ ______________________________
Printed Name of Responsible Party SSN#

Email Address ____

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.