HIPAA PRIVACY FORM
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

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

_____ (Date}_____
(Signature of Patient and/or Guardian)

(Relationship to Patient) Self or Other: _____

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
- ☐ Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement at time of service
- ☐ Other (Please specify) _____

Our Business & Financial Philosophy

It is important to us that the quality of our business services matches the quality of our dental care. We want the handling of your account, from the start to be perceived as an extension of the dental care we provide you and your family.

All appointments are exclusively reserved. Therefore, a two-business day notice is required for any change in scheduling for short visits. For any appointment scheduled for 1 ½ hours or more, a one-week notice is required for any changes in scheduling. Our office does not accept answering machine or voice mail messages as a change of scheduling. All appointments are to be handled by our front office team during our regular business hours. We reserve the right to charge a fee of $75 per half hour of reserved treatment time for any changes in schedule without sufficient notice.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to pay for your treatment at time of services. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.
So that we may file your insurance claim(s) correctly, we ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your benefits.

Regarding Insurance
We file insurance claims for all patients with insurance benefits. We accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 45 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 45 **days.**

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, AMERICAN EXPRESS Ask us about EASY PAY OPTIONS
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Scarsdale Dental Spa must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Scarsdale Dental Spa. I give consent for any credit check to be completed by Scarsdale Dental Spa should it be deemed necessary.**

I have read the Business & Financial Philosophy. I understand, accept, and agree to this Business & Financial Philosophy.

_____ _____ _____ _____
Signature of Patient or Responsible Party Date Witness for Scarsdale Dental Spa Date