Innovation Dental Center

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 acknowledge that **I have received your *Notice of Privacy Practices***

____
{Please Print Name}

____ ____________
{Signature} {Date}

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

____ ____________
{Please Print Name} {Relationship}

____ ____________
{Please Print Name} {Relationship}

____ ____________
{Please Print Name} {Relationship}

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 prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

© 2002 American Dental Association
All Rights Reserved

Innovation Dental Center

1111 Park Avenue, Suite L-109, Baltimore, MD 21201
E-Mail: InnovationDentalCenter@gmail.com
Web: www.InnovationDentalCenter.com
P: 410-383-7070 F:410-383-1988

FINANCIAL POLICY

Thank you for choosing ***Innovation Dental Center*** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, OR CREDIT CARDS
WE OFFER PAYMENT PLAN

Regarding insurance

We do accept assigned of insurance benefits. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not part of that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically become your responsibility.
Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Service Charges

The policy of this office is to charge 1% monthly interest (12% annual percentage rate) or a billing charge that will be applied to all accounts over 90 days past due. We will charge $35 for returned checks.
For those patients who have an unpaid balance of over 60 days, we will add a 1.75% interest per month service charge and a 21% yearly interest charge onto your account balance. On accounts past due 90 days, the patient/responsible party will be responsible for all collection costs, court cost, and attorney's fees related to collecting the unpaid balance. Please understand that you are responsible for the balance due on your account as a result of any and all professional services rendered by this office, regardless of your insurance status.

Minor Patients

For unaccompanied minors, we ask that financial arrangements be made prior to the day of their appointment. The adult accompanying a minor and the parents (or guardian's of the minor) are responsible for full payment.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of normal office visit. Please help us serve you better by keeping scheduled appointments and being on time.
Thank you for understanding our financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

______________________________ ______________________

Signature of Patient or Responsible Party **Date**