Happy Rock Dental

5601 N Antioch, Suite 5
Gladstone, MO 64119
816-455-1200

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & 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.

Your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information is available to me to read. 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 at 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 private 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 agree then you are bound to abide by such restrictions.

Patient Name/Signature: _____

Parent/guardian Signature: _____

Date: _____

FINANCIAL AGREEMENT

As a courtesy, my insurance company will be billed on my behalf. I agree that all fees for service are payable by the insurance company to Happy Rock Dental. My dental insurance is a contract between myself and said insurance company and not a responsibility of the practice. I understand that regardless of any dental insurance, I am responsible for my dental fees. I also understand the responsibility for payment of dental services provided in this office for myself or my dependents is due and payable at the time services are rendered unless financial arrangements have been made.

Since we reserve your time slot, I understand that a $40.00 fee **WILL** be assessed to my account for a **NO SHOW**. A **24 hour notice** is required to cancel an appointment, however, if I am unable to give this notice, I may be assessed the $40 fee. Continued missed appointments will result in loss of future appointment privileges.

Further, I will be responsible for all court costs, collection fees, and attorney's fees in the event of non-payment.

Patient Signature: _____ Date:_____ Witness: _____

Parent/Guardian Signature (if patient is a minor):_____