TYSON
FAMILY DENTAL

Acknowledgement of Receipt of Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. **By my signature below I give permission to use and disclose my health information.**

Patient Name: _____

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Patient or Legally Authorized Individual Signature Date

Financial Policy

I understand it is my responsibility to inform and update this office of any changes in dental insurance coverage and also update any changes in address or contact phone numbers. I understand that this office requires 24 hour notice in order to verify coverage. If adequate notice is not given, I am aware that it is my responsibility to reschedule my appointment or pay the full fee of the visit. All dental services provided, whether the patient has dental insurance or not, are charged directly to the financially responsible party and that he or she is personally responsible for payment of all dental services rendered.

If the insurance company has not paid a claim after 60 days of being submitted, this office will require the patient to pay the account balance unless other arrangements have been made. It is your responsibility to know your plan and its limitations including but not limited to your deductible, plan maximum and coverage details.

Dr. Matt Tyson, D.D.S., P.C. routinely provides our patients with an estimate of cost for the purposed treatment. Since your insurance determines the benefit payable for services, this office ***cannot*** be held responsible for 100% accuracy on what is ***only*** an ***estimate*** for treatment. This office provides only an estimate based on your insurance coverage. All insurance companies provide a disclaimer when insurance benefits are being quoted: "Information is subject to change. Benefits described are not a guarantee of payment. Actual benefits payments are determined only when a claim is received, eligibility is not a guarantee of coverage." If an account is turned over to a collection agency and or attorney for collection, the account holder will be responsible for all attorney and collection fees**. Any account that is 90 days past due is subject to being sent to collections unless other arrangements have been made.**

I hereby verify with my signature below that I have read and understand the office policies stated above and also grant Dr. Matt Tyson, D.D.S., P.C. and or affiliates permission to contact me in matters related to this form.

Patient Name: _____

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Patient or Legally Authorized Individual Signature Date