Name: _____

Address: _____

Phone: Home: _____Work:_____Cell:_____

Email: _____

Acknowledgement of Privacy Practices: I understand and agree to allow the following:

- To allow Rainier Dental to coordinate or provide any treatment information to other health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to chance the *Notice of Privacy Practices.* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.
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 and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____ Date: _____

Relationship to patient: _____

Dependent family members also covered by this acknowledgement: _____

_____

Additional Disclosure Authority:

_____

FOR OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgement due to the following (mark one)
O -patient refused to sign O- communication barrier O-Emergency situation O-other

Financial Arrangements with Rainier Dental:

Patient portion is due at the time of service. I hereby authorize the release of any information needed and authorize my insurance company to pay directly to Rainier Dental, benefits accruing to me under my policy. If the information that I have provided is inaccurate, incorrect or I am ineligible under the Dental Benefit Plan Agreement, then I understand that I am responsible for all charges for dental services provided for myself or my dependents. Also, I understand that any discussions concerning benefit coverage is **ONLY AN ESTIMATE** of payment and is subject to change based upon information provided by your Dental Benefit Plan. Any changes in patient insurance benefit information will be provided to Rainier Dental as soon as available and I understand that I am responsible for payment regardless of the status of insurance claims. Payment options include cash, check, Visa, MasterCard, American Express, Discover and Care Credit. There will be a $50 fee assessed for any payment returned by your bank. Any outstanding balance over 60 days will be assessed a finance charge equal to 18% interest annually.

Office Policy:

_____ It is our policy that for the privacy and safety of our scheduled patients that **ONLY PATIENTS** will be allowed to stay in the treatment area while dental treatment is being provided. Parents may seat their children and return to the reception area unless the rendering Doctor has requested otherwise. No other family members will be allowed in the back office during treatment procedures.

_____ Minor children (**17 and under**) will not be treated without the presence of a consenting adult. If this adult is NOT the parent or legal guardian, we have a release form for you to sign authorizing another adult to make treatment decisions.

Please, no cell phone use in our office. You may step outside to accept or make personal calls. Thank you for your consideration concerning these important issues.

Cancellation Policy:
Our office requests that any patient cancelling or rescheduling an appointment to please notify our office within 48 hours of that appointment time. Late cancellations or broken appointments are subject to a $50.00 charge per half hour. Saturday appointments must give notice for cancellations or weekend appointments will not be rescheduled. Rainier Dental reserves the right to refuse service to any patient for any reason.

Signature of Responsible Party:_____ Date:_____

Print Name: _____

Relationship to Patient: _____