Name:____

Address:______________________________________

Phone: Home:____________Work:____________Cell:____________

Email:____

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 CareCredit. There will be a $50 fee assessed for any payment returned by the bank.

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.

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). If the patient is a minor, a parent or legal guardian must sign.
Please specify below if any other person (s) have access to your protected health information.

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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 must have a consenting adult in the office during any dental visit for the duration of the visit. If that 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 ask if you need one of these forms. Please, no cell phone use in our office. You may step outside to except 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:__________________________Date:______________