Dental Expressions

HIPAA Notice of Privacy Practices;
Office Financial and Dental Insurance Policy; Patient Consent for Services

Patient Name: _____

Date: _____

HIPAA Notice of Privacy Practices

Dental Expressions is required by law to maintain the privacy of your dental information and provide patients with our HIPAA - Notice of Privacy Practices. This form is a notice of our legal duties and privacy practices with respect to your Public Health Information.

The signature below acknowledges receipt of a copy of the HIPAA Notice of Privacy Practices.

Office Financial and Dental Insurance Policy

All patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and *patients are personally responsible for payment of all dental services*. Dental Expressions will help prepare the patient insurance forms and/or assist in making collections from insurance companies, and will credit any such collections to the patient's account.

Fees generated by Dental Expressions providers are not governed by the provisions of patient insurance policies. Our office is not responsible for collecting your insurance payment or negotiating settlements on disputed claims. Each patient – *not the insurance company* – is responsible for payment of their bill. Patient payment is due at time of service.

I authorize the release of any dental information necessary to process claims for services provided; and authorize payment of dental benefits to Dr. Patrick F Carroll.

The signature below acknowledges receipt of a copy of the Office Financial and Dental Insurance Policy and agreement with its content.

Consent for Services

I hereby voluntarily consent to dental treatment as deemed necessary by Dr. Patrick F Carroll.

I understand that it is a policy of the practice to contact patients by phone, mail and/or email to remind them of appointments. I grant permission to Dental Expressions to telephone me, at any number provided, to discuss matters related to my treatment.

The signature below acknowledges consent for services provided by Dental Expressions providers.

X _____
Patient Signature (or parent/guardian if patient is a minor)