ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of the Statement of Privacy Practices (Statement) for the office of Nannette Goyer, DDS, PLLC dba Inland Family Dentistry (Facility). The Statement describes the types of uses and disclosures of my Protected Health Information (PHI) that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement also describes my rights and the responsibilities and duties of this office with respect to my PHI. The Statement is also posted in the facility. The Facility reserves the right to change the Statement at which time I will be offered a copy of the revised Statement at the time of my first visit after the revisions become effective. I may also obtain a revised Statement by request.

In addition, I hereby specifically authorize disclosure of my PHI to the person(s) identified below. I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, PHI cannot be shared with anyone unless otherwise allowed by HIPPA rules.

Spouse Only	❑ YES	❑ NO
OR		
Any Member of Immediate Family (Spouse, Children, Children's Spouses)	❑ YES	❑ NO
Any Member of Extended Family (Parents, Grandchildren)	❑ YES	❑ NO
Other (Please List):	❑ YES	❑ NO

Name of Patient (Print)		
Patient Signature (18 years old or older)		
Patient's Personal Representative (Print)		
Personal Representative's Signature		
Representative Phone Number		**Date:**

FINANCIAL POLICIES

By offering treatment estimates prior to services, we hope to eliminate confusion regarding co-payment responsibility and simplify insurance claims. Please review the following information so that you are aware of our policies:

- CO-PAYMENT—**Payment by check, cash, Visa, Mastercard, American Express, or Care Credit is <u>due on the day services</u> are rendered.** Your co-payment is the amount your insurance will not cover for the services provided. Your co-payment is calculated based on the best available information from your insurance company. Please note **<u>interest will accrue</u>** after 60 days at 18% APR/ 1.5% monthly.
- INSURANCE—For our patients with dental insurance, our professional services are rendered to you, not your insurance company; therefore, you are responsible for payment for services rendered. As a courtesy, we do accept assignment of benefit payments from your insurance company. This will reduce your immediate out-of-pocket expenditures. Any insurance estimates we give you are based on limited information obtained from your insurance company. Insurance companies calculate what they pay based on the contract signed with your employer, not the doctor's fees.
- CANCELLATION/ NO SHOW FEE—Please help us serve you and our other patients better by keeping scheduled appointments. **<u>If a 24-hour courtesy notice is not given, a $25 fee will be charged</u>**.

By my signature below, I acknowledge that I have reviewed and understand the Financial Policies. My signature also authorizes the release of any medical and/or dental information required by my insurance carrier.

Print Name:	Signature:	Date: