FINANCIAL AGREEMENT / ASSIGNMENT OF BENEFITS

I understand that my estimated share of cost is *due and payable on the day the treatment is performed*.

I authorize Dr. Smith's office to bill my insurance. I further understand that dental insurance may cover only part of my dental treatment, and that any estimate given is only an ESTIMATE based on my dental benefit plan. I also understand that the contract for dental insurance is between me and my insurance company. It is my responsibility to know and understand my benefits. Any dispute of coverage needs to be handled through my insurance company directly.

It is also my responsibility to inform the office of any changes that may occur, such as change of address, or insurance policies.

I accept as my personal responsibility all charges to my account as a result of this agreement. We will send a final statement for any treatment not covered by my insurance company. *I understand that any final balance is due within 30 days of my billing.*

I further understand that 1 1/4% finance charge (15% annually) will be added to balances over 60 days. In the event of default in payment, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees that may be required to effect collection of debt.

ACKNOWLEDMENT OF PRIVACY PRACTICES

My signature confirms that have been informed of my rights to privacy practices regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment, directly and indirectly
- Obtain payment from third-party payors for health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental providers 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 said notice. I understand that my dental providers has the right to change the notice and that I may contact this office to obtain a current copy of said notice. I understand that I may request in writing that you restrict how my 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, then you are bound to abide by such restrictions. I may also request a copy of the material data fact sheet which defines the material used in this practice.