# Financial Agreement

Patient Name _____DOB _____

If pt is under 18 Responsible party Name _____DOB _____

Patient SS# _____ Patient's Employer _____
(If patient under 18 responsible party ss#) (If patient under 18 responsible party employer)

I understand that I am responsible for full payment for services rendered (or if I have dental insurance my estimated portion of the balance) on the date of service, unless other arrangements have been agreed upon with Dr. K Family Dentistry. I acknowledge that any estimate of what insurance will cover is only an estimate and could be different once the claim is processed through my insurance company. If there is a balance after the claim is processed, I agree to pay that balance or make payment arrangements within 30 days of receiving a statement. I acknowledge that I am responsible for verifying my own insurance benefits and although Dr. K staff may help with this Dr. K Family Dentistry is not responsible for verifying my coverage, it is ultimately my responsibility to be aware of the details of my plan, coverages, exclusions, limitations, etc.

X_____ Date _____
Patient or Responsible Party Signature (if patient is under 18)

# HIPAA Acknowledgement and Consent

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

-Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

- Obtain payment from third-party payers.

-Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received, or have the right to request Dr. K Family Dentistry's Notice of Practice Policies (available at front desk) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Dr. K Family Dentistry at any time at the address above to obtain a current copy of the Notice of Private Practices.

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. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Name of person(s) we may share information with and contact in case of emergency (Please list at least 1):

Name_____Relationship_____ Phone # _____

Name_____Relationship_____ Phone # _____

Name_____Relationship_____ Phone # _____

Name_____Relationship_____ Phone # _____

X_____Date _____
Patient Signature (Or parent/guardian if pt is under 18 )