WELCOME TO OUR OFFICE!

Our office is committed to providing the highest quality dental care at a reasonable cost. Thank you for trusting us with your care. Please take a few minutes to read and completer the following forms. If you have any questions or need assistance, please feel free to ask. Once again, welcome!

NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I UNDERSTAND THAT, UNDER THE Health Insurance Portability and Accountability Act (“HIPAA”), I have certain rights to privacy with respect to my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in my treatment, directly and indirectly.
2. Obtain payment from insurance companies or third-party payers.
3. Conduct normal healthcare operations such as assessments and physician certifications.

I have received, read and understand this Notice of Privacy Practices. I understand that this office has the right to change it Notice of Privacy Practices from time to time and that I may contact this office at any time at the address below to obtain a current copy of its Notice of Privacy Practices.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I understand that this office is not required to agree to my requested restrictions and that if this office does agree that it is bound by such restrictions.

FAILED APPOINTMENT / CANCELLATION POLICY

Our office policy requires a 24 hour notice of an appointment cancellation. We understand that there are times when this is not possible, however if there are two broken appointments without 24 hour notice the Dr. will be forced to provide emergency services only, for a 30 day period to allow you to establish care with another dentist.

PAYMENT POLICY

Payment is expected at the time services are rendered unless prior arrangements have been made. We expect that your account will be cleared within 60 days. If financial arrangements have been made, the remaining unpaid balance may be subject to a FINANCE CHARGE at the ANNUAL PERCENTAGE RATE of 18%. There will be a $25 fee for all returned checks.

INSURANCE ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have the insurance coverage disclosed and assigned directly to Rhett M. Tipton, DMD, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. Rhett M. Tipton, DMD, PC, may use my health care information and may disclose such information to my insurance company and its agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This release of information will remain in effect until revoked by me in writing.

____________________________________ Signature of Patient or Responsible Party	____ please print name of Patient or Responsible Party
____________________________ Date	____ Relationship to Patient