COMPREHENSIVE
DENTAL CARE

Gregg C. Hendrickson DDS and Oanh Y. Le DMD

Please read our NOTICE OF PRIVACY PRACTICE, PRACTICE POLICIES, CANCELLATION POLICY and INSURANCE COVERAGE POLICY. **If you do not understand any of these, please ask our receptionist to explain our policies to you.**

Patient Name:_____ Date of Birth:_____
Please Print

NOTICE OF PRIVACY PRACTICE

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice Privacy Practice on request.

PRACTICE POLICIES

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the care coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges and any other expenses incurred in collecting your account.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

CANCELLATION POLICY

I understand that the office requires that two business days' notice when cancelling a scheduled appointment. If sufficient notice is not given, I understand that I will be charged a **cancellation fee of at least $50.**

INSURANCE COVERAGE

We do our best to estimate your dental insurance coverage. However, our office can *only estimate dental insurance coverage*. Coverage is dependent on many factors some of which we may not know. You will be responsible for any outstanding balance after your insurance company has paid your claim regardless of our estimate.

I have read the NOTICE OF PRIVACY PRACTICE, PRACTICE POLICIES, CANCELLATION POLICY and INSURANCE COVERAGE information above. I understand all four of these statements. I agree to all four of these statements.

Signature:_____ Date:_____
Please sign.

Relationship to patient (if signed by representative or parent of patient):

_____