Lake Hills Family Dentistry

Privacy Practice and Office Policies

Notice of Privacy Practice Acknowledgement:

We keep a record of the health care services we provide you. You many ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager during normal business hours. Our Notice of Privacy Practice describes in more detail how your health information may be used and disclosed, and how you can access your information.

- By my signature below, I acknowledge receipt of Notice of Privacy Practices.
- I authorized Dr. Malyon to release information required for insurance claims and referrals to specialists.

Signature (Responsible Party):_____ Date:_____

Relationship to patient:_____

Office Policies:

Treatment: We believe all treatment diagnosed and agreed upon should be completed. Incomplete treatment can lead to complications and problems.

Financial: As a service to our patients, we will contact your insurance carrier for your dental benefits. However, we are not responsible for any incorrect or incomplete information provided. The patient is responsible to pay all charges not covered by insurance within 30 days. However, when the cost of necessary treatment exceeds your budget, we have available options for extended payment.

Cancellations: An appointment in our schedule is a bond of trust that we will be here to serve you and you will be present for the treatment. Every effort is made to ensure that you are aware of your upcoming appointment through phone calls, postcards and emails. We require 2 business days to reschedule or cancel appointments. **A $50 fee will be assessed if the required time is not met.**

- By signing below, I accept and acknowledge receipt of our financial and cancellation policies.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on this account for any professional services rendered.
- I authorize insurance payment to be paid directly to Dr. Jeff Malyon.

Signature (Responsible Party):_____ Date:_____

Relationship to patient:_____