Patient Privacy Practices / Treatment Consent / Office Information

- I have been informed of the existence of the Harborside Dental Associates patient privacy practices. At any time I may request to review the Patient Privacy Policy and also request a copy of such form.
- I understand the information gathered is necessary to provide me with the best and most appropriate dental care possible. I have answered all the questions truthfully and to the best of my knowledge. I guarantee that the information provided is an accurate, all-inclusive representation of my health at this time. Should further information be needed, I give Harborside Dental Associates permission to ask the respective health care provider or agency, who may release such information to Harborside Dental Associates.
- I understand that it is my responsibility to inform Harborside Dental Associates of any changes to the information provided.
- I authorize the Doctor(s) or designated staff members to take x-rays, study models, photographs and any other diagnostic aids necessary to provide me with an accurate diagnosis and treatment plan. Upon diagnosis, I authorize the Doctor(s) to perform all recommended treatment and/or therapy mutually agreed upon by me.
- I understand that with all dental treatment, there are risks. I will discuss these risks and any concerns that I may have, with the Doctor(s) prior to treatment.

Release of Information

PLEASE LIST ANY OTHER PARTIES WHO MAY HAVE ACCESS TO YOUR DENTAL HEALTHCARE INFORMATION

(This may include spouse, parents, step parents, grandparents, adult children, siblings, legal guardian, close friend, neighbor and/or any care giver that we may communicate with, for the purpose of but not limited to: confirming appointments, changing appointments, discussing treatment plans, discussing financial arrangements, answering questions regarding prescription or over the counter medications the Doctor(s) may recommend).

□ Only Myself
□ Myself and those listed below:

Name	**Relationship**	**Phone #** **(if not on file)**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL HEALTHCARE APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

□ Home Phone □ Cell Phone □ Work Phone

□ Email ■ U.S. Mail

_____ *Initial*
- I understand that payment is due at the time services are rendered. Harborside Dental accepts cash, credit cards (Visa, MasterCard and Discover), personal checks and Care Credit.

_____ *Initial*
- A service charge of 1.5% per month (18% annually) will be applied to any balance over 60 days without having payment arrangements made in advance. ***Should my check be returned by my bank for any n on-payment, a $25.00 fee will be charged to my account along with the amount of my check.***

_____ *Initial*
- I understand that I am responsible for any legal fees, collection agency fees, interest charges and any other expenses incurred to Harborside Dental Associates while attempting to collect on my account.

_____ *Initial*
- All presented treatment plan fees will be honored for a period of 6 months from the date of my exam.

_____ *Initial*
- As a courtesy, Harborside Dental Associates will submit my insurance claims to the insurance company that I have provided information on. I have been informed that Harborside Dental Associates does ***NOT*** verify ***my*** eligibility or ***my*** benefit coverage. I am aware that ***not*** all recommended treatment is a covered benefit and that it is ***my*** responsibility to contact ***my own*** insurance company with any covered benefit concerns. Harborside Dental Associates will make all efforts to collect from ***my*** insurance company and assist in any collection concerns from them. **Insurance is not a guarantee of payment and I understand that I am ultimately responsible for all charges incurred.**

_____ *Initial*
- **We ask that you provide us with at least 24 hours notice for any reserved appointment that you cannot keep.** ***If you have more than 2 broken or cancelled appointments without 24 hours notice, it may be required that you*** **prepay** ***in order to reserve another appointment.***

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy and Financial Practices for Harborside Dental Associates, PA. A copy of this signed, dated acknowledgement shall be as effective as the original. My signature will also serve as a PHI document release should I request records be sent to another attending dental office in the future.

Date: _____ _____ _____

PRINT PATIENT NAME **Patient Signature (Parent-Guardian)**