DAVID WICKNESS, DMD

BELLE MEADE • NASHVILLE

CONSENT FOR SERVICES AND FINANCIAL POLICY

As a condition of treatment by this office, payment in full or insurance co-payments are due at the time of service. Our office depends upon reimbursement from patients for the cost incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. As a courtesy, our office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Personal checks are accepted with proper identification (drivers license or photo ID). A $25.00 overdraft charge will be added to return checks. We require 24-hour cancellation notice for a scheduled appointment. Patients who fail to show for their scheduled appointment, without giving notice, will be charged a $50.00 fee. This is not payable by your insurance.

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

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

I understand the above information and agree with its contents.

Signature _____ Date _____

HIPAA ACKNOWLEDGMENT

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand the above information and agree with its contents.

Signature _____ Date _____