THIELBAR FAMILY DENTAL
1332 E. APPLE AVENUE
MUSKEGON MI 49442
(231) 777-7931

NEW OFFICE POLICY EFFECTIVE 01/01/2015

We would like to thank you for allowing us to provide your professional dental care. We appreciate our patients for their consideration in keeping and showing up on time for their appointments. This along with other items, have become a problem for some patients. As a result we are now requiring the following from our patients:

- ***Our office will charge patients a $25.00 missed or cancelled appointment fee if 48 hours notice is not given (with a special exception of medical emergencies and family emergencies). We realize there are times that unforeseen circumstances can not be avoided, and we will consider each of those circumstances on an individual basis.*** **Initials** __________

- We still continue to require all payments at the time of service, which includes: payments in full if no insurance, and/or any co-payments estimated with insurance. This is just an estimate and you will be responsible for the balance if your insurance does not pay what was estimated. Any estimates given are only to assist you and are not a quote or agreement to only charge that amount.
  Initials __________

- There will be a 1.5% monthly (18% APR), finance fee charged on all unpaid balances and/or a $5.00 billing charge. **Initials** __________

- Any patient, whose account has to be taken to small claims court, or any other collection method for an unpaid balance, will be considered not to be in good standing and no further treatment of any type will be rendered to the patient and the entire family at this practice. **Initials** __________

- There will also be a $25.00 charge for any check returned due to non-sufficient funds available. **Initials** __________

- Any unclaimed credits will be forfeited after 2 years. **Initials** __________

Date: ______________________________

Signature of Responsible Party: ______________________________

All family members listed on the account:

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ** Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ** Obtaining payment from third party payers (e.g. my insurance company)
- ** The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

____
Patient or Guardian Signature

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Date

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Patient Name(s) – Please print*
*If parent or guardian is signing for minors in account, please list all minors names

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