

Ann M. Campbell, DMD, FAGD
Laser and Integrative Dental Medicine Of Northern Nevada
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(775) 853-1999/Fax (775) 853-1935

Our office is fully committed to compliance with HIPPA guidelines by:

1. Providing appropriate security for our patients' dental records.
2. Protecting the privacy of patients' dental records.
3. Providing our patients with proper access to their dental records, once a signed release is obtained.
4. Appropriately maintaining our patient information and billing process in compliance with national HIPPA standards.
5. Not providing patient data to marketers or pharmaceutical companies for purpose of research.

If a family member calls or comes in for information regarding your treatment, to whom may we release this information? Please include their name and relationship.

Name _____ Relationship _____

Financial Agreement

I understand that I, as the patient, am fully responsible for payment on my account with Laser and Integrative Dental Medicine of Northern Nevada, regardless of any insurance coverage. I understand that payment is expected the day of my procedure as outlined verbally and/or written financial arrangement. Cash, check, MasterCard/Visa/Discover are accepted by this office. I understand that if my insurance company fails to reimburse this office for services rendered within 30 days, the balance will become my responsibility, and will be due immediately. Any accounts payable over 60 days will be subject to an 18% rate of interest monthly, on the balance due and may be turned for legal collection of any overdue amount. I understand that the returned check fee is \$25. **Any insurance estimates given, is just that, an estimate. It is not a guarantee of payment from the insurance company.**

Missed and/or cancelled appointments

We try faithfully to respect your valuable time by seating you promptly, unless emergency patients have delayed us. Emergency patients are always a part of our practice and we strive to take care of all of our patients with compassion, especially those in discomfort. Should there be an unavoidable delay in your treatment time, every effort will be made to contact you ahead of time. In order to provide care in a timely manner, we ask that **48** hours notice be given should you need to reschedule or cancel an appointment. Your personal appointment time scheduled is made exclusively for you. **When you do not provide at least 48 hours notice, we reserve the right to charge \$75 per half hour of scheduled appointment time.** No further appointments will be scheduled until the fee is paid. We understand that family emergencies do happen and that unforeseen circumstances do occur. Please notify our office as soon as possible to discuss your individual situation.

Release of Information

I authorize the release of any information, regarding the course of my examination and treatment, to my insurance company, and/or any specialist I may see. I further authorize Laser and Integrative Dental Medicine of Northern Nevada to obtain information from any source deemed necessary for my treatment. A copy of this authorization shall be considered as effective and valid as the original.

Assignment of Benefits

I authorize and assign any payment directly to Laser and Integrative Dental Medicine of Northern Nevada. My consent is granted to use this original or a copy as effective and valid as the original.

I have read the above privacy policy, financial agreement, missed and/or cancelled appointment, release of information and assignment of benefits, and agreeing to the terms mentioned, do hereby sign my name.

(Print) (Sign) (Date)

Parental Consent to Treat Minor Child

I, _____, give permission to Dr Campbell, and her staff/associates, to evaluate and treat my minor child.

(Minor name) (Date of birth) (Parent/guardian sign) (Date)