Notice of Privacy Practices Acknowledgement

Erieview Dental

9510 Diamond Centre Dr.

Mentor, Ohio 44060

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Financial Policy

In order to prevent any misunderstanding, we ask all patients to read and sign our Financial Policy.

1. **Insurance Coverage**: As a courtesy to our patients, we will verify insurance for eligibility benefits prior to the first appointment as well as submit claims to your insurance company for you. The insurance companies **DO NOT guarantee payment based on the information that they provide us. You are ultimately responsible for any costs not covered by your insurance company.**
2. **Payment:** Payment is due at the time of service. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.
3. **Payment Options**: In addition to cash, checks, Visa, MasterCard, and Discover, we offer several payment plans through Care Credit. Please ask our patient service representatives for details.
4. **Returned Checks**: There will be a $30.00 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification. Once a check has been returned twice, we will no longer be able to accept personal checks for payment.
5. **Over Due Accounts**: In the event your account is turned over to a collection agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees. Once an account is placed in collections, form of payment will be cash, credit card, or certified money order only. No personal checks will be accepted.

I have read and understand the above information; I understand and agree to all financial policies of Erieview Dental.

Print Name: _____ **Date:** _____

Signature: _____