Little Smile Makers
4536 Dublin Blvd
Dublin, CA 94568
Phone: 925-828-9000
Fax: 925-828-8855

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I understand that I have the right 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 also have 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 protection 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 health information is used and disclosed to carry out treatment, payment, and healthcare 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 these restrictions.

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

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with

your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company.

Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover.
Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care at Little Smile Makers. In an attempt to be consistent, we have a **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for your child and when it is missed, that time cannot be used to treat another patient.

We require that you give our office **48 hours** notice prior to any cancellation. This allows for other patients to be scheduled into that appointment. If your child misses an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$75** will be charged to you; this fee cannot be billed to your dental insurance and will be your direct responsibility.

Additionally, if your child is 10 minutes late without prior notice for their scheduled appointment, we will consider this a missed appointment and the **$75** cancellation fee will be charged.

I have read and understand the Appointment Cancellation Policy of Little Smile Makers and

I agree to be bound by its terms. I also understand that such terms may be amended by Little Smile Makers.

SIGNATURE ON FILE

I hereby authorize payment directly to the dental practice listed above of the dental benefits otherwise payable to me.
I understand my signature is valid from the above date, unless revoked by me at an earlier date.

The above listed dental practice and its staff is authorized to provide any insurance company(s), claim administrator(s) and consulting health care professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract.
I know I have a right to receive a copy of this authorization upon request.