Notice of HIPAA Privacy Practices

We will only use your private information to provide treatment and to procure payment. This means that we may need to share your information with another office providing specialty care for you, your insurance, or with our electronic billing service. We will not share your information with anyone else without your permission.

A copy of this office's Privacy Practices has been made available.

_____

Signature Date

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding my care.

_____

Please print name Relationship

CANCELLATION POLICY

We reserve your appointment time just for you, and we require a minimum of 24-hour notice to change an appointment. All appointment changes must be made on the phone during regular office hours (Monday-Thursday, 8-5), as our text and voicemail are not monitored for schedule changes. Cancellations without a 24-hour notice are subject to a $50 charge. Appointment blocks longer than 1.5 hours require a $100 deposit to secure appointment- this charge will be applied towards treatment balance on date of service.

Initials: _____

FINANCIAL POLICY

By signing below, I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/ updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec.12-1-11. The terms of this paragraph shall apply to all amount(s) are incurred today or after today. I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/ cellular phone numbers and/or email) provided by me or anyone associated with me or acting on my behalf to TimberRidge Dental or anyone acting on its behalf. Under H.B. 128 if any amount due is not paid by due date on statement or as agreed, TimberRidge Dental will report patient due amount to a collection agency that may affect the patients credit score. I authorize TimberRidge Dental to share information given by myself for me or any of my children that I am guardian of, to any provider that I provide.

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Signature of patient, parent, or guardian Date Relationship to patient