Broken Appointments

Rocky Mountain Dental Clinic requires 24 hours prior notice if any patient is unable to make their appointment for any reason at all. Therefore if the appointment is cancelled less than 24 hours before your appointment the patient will be charged a "Broken Appointment" fee, which is $25.00. Continual missed or broken appointments could result in the patient being placed on a short call list and or dismissal from the practice. _____ **INITIALS**

Consent for Electronic Messages and/or Mailings

I consent to having reminders emailed, texted or mailed to me. I am aware that these reminders show the date and time of my appointment, as well as what the appointment is for (dental hygiene appointment), which is in violation of HIPAA. By signing below, I will not hold Rocky Mountain Dental Clinic accountable for violating his HIPAA regulation.

For text message appointment reminders please provide the preferred phone number: _____
For email appointment reminders please provide the preferred email address: _____

_____ **INITIALS**

Financial Arrangements

We ask that you pay for services as services are rendered. Dental insurance is a contract between you and your insurance company. We will do our best to work with your insurance company. At each visit you will be required to pay your estimated portion not covered by insurance, unless prior arrangements have been made. If accounts go beyond 90 days a finance charge will be applied to your account. That rate will be no less that an annual rate of 20%. I understand that should I default on payment of my account and collection agency services are required, I will be responsible for all costs of collections up to 45% of the balance, including attorney/court costs that will be added to the balance of my account. _____ **INITIALS**

Patient Signature on File

I hereby authorize that Brandon Sheahan, DMD, to keep this document on file as it represents my consent in filing for dental insurance payment of any dental procedures he has performed for myself or my dependents. Payment of dental insurance benefits, otherwise payable to me, will be made directly to Brandon Sheahan, DMD.I authorize the release of any information relating to these insurance claims necessary for the filing of insurance. _____ **INITIALS**

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

➢ **You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgements