Mount Vista Family Dental

Vancouver, WA 98604

ACKNOWLEDGEMENT OF RECEIPT – NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Mount Vista Family Dental. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Mount Vista Family Dental reserves the right to change the privacy practices currently described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA.) If you would like a copy of the Privacy Practices, please let the front desk know.

Spouse Only: ☐ **YES** ☐ **NO**	**Spouse's Name:**	
Partner Only: ☐ **YES** ☐ **NO**	**Partner's Name:**	
Any member of my **immediate family** (Spouse, Children, Children's Spouses) ☐ **YES** ☐ **NO**		
Any member of my **extended family** (Parents, Grandchildren) ☐ **YES** ☐ **NO**		
Patient's **Personal Representative**: ☐ **YES** ☐ **NO**		
Representative Name:		**Telephone No:**
Representative's Signature:		
OTHER: ☐ **YES**	**Name:**	**Tele #:**
Patient's Name: (Please Print)		
Patient's Signature		

Acknowledgement Not Obtained				
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Provided:**	
Reason for not obtaining patient signature:	☐	**Needed more time**	**Wanted to consult another person**	
	☐	**Physically unable to sign**	☐	**No reason offered**
	☐	**Other:**		
	☐			

MOUNT VISTA
FAMILY DENTAL

Joshua M. Hiller, D.D.S

OUR FINANCIAL POLICY

Mount Vista Family Dental believes that part of a successful dental treatment plan is a clear mutual understanding of the costs involved and the payment terms expected. Please read and sign the financial policy agreement below prior to beginning treatment. We attempt to make each patient aware of the costs of treatment prior to beginning that treatment and will work with you to estimate what will be owed (deductibles, copayments, and non-covered expenses) after insurance. Please ask if you are at any point unsure of your financial obligation.

COPAYMENT IS DUE ON THE DATE OF SERVICE BY CASH, CHECK, OR MAJOR CREDIT CARD.

The patient understands that delinquent accounts will be assigned to a credit reporting collection service after 3 failed attempts to collect the account balance.

DENTAL INSURANCE

We are happy to file insurance claims on behalf of the patient. However, the patient is responsible for timely payment of all dental fees, regardless of coverage. The patient understands that dental insurance is a contract between them and the insurance carrier, and that the dentist is not party to this contract. If insurance has not paid within a timely manner, the patient is responsible to pay the full balance. Any insurance benefits subsequently allowed will be refunded to the patient or, if desired, held on account towards future treatment.

INSURANCE ESTIMATES

Estimated insurance benefits are ESTIMATES only and do not constitute a guarantee of coverage or relieve the patient of their obligation to satisfy their bill in full. In order for the patient to be fully aware of the benefits which their particular policy provides, they are encouraged to contact their insurance carrier and/or familiarize themselves with the limits and provisions of their policy. Upon request, the office will submit proposed treatment to the insurance carrier for review and pre-estimation. (Most insurance companies will need 4 to 8 weeks to process.) The patient should make the office aware of any changes to their insurance prior to their appointment.

MISSED APPOINTMENTS

The doctor reserves appointment times exclusively with each patient. We are committed to being here to serve you and ask that you honor your commitment to us as well. The office reserves the right to charge a **missed appointment fee of $40 for short notice cancellations (less than 48 hours' notice) barring sudden illness.**

I have read the Financial Policy above. I understand and agree to abide by the terms of this policy.

Signature_____ Date_____

Print Name_____

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