

CHARLES C. NUNNALLY, D.D.S.

Dental Depot • 3326 Forest Lane • Dallas, Texas 75234 • Phone (972) 488-2123 • Fax (972) 243-3690

INSURANCE AND PAYMENT POLICY

We file insurance as a courtesy to our patients. Payment for any amount not covered by your insurance plan is due at the time of service, unless specific payment arrangements have been made beforehand. Your insurance policy is a contract between you and your insurance company. Please remember that you are ultimately responsible for your payment. Your insurance company does not attempt to cover all of your dental expenses. It is your responsibility to pay any deductible, co-insurance, or any balance which is not paid by your insurance company. For your convenience, we accept cash, Visa, Mastercard and Discover. We also offer outside financing. Please ask one of our staff about this.

APPOINTMENT POLICY

The appointment we reserve for you is very important. As a courtesy, we will call to remind you of your appointment. Please give 24 hours notice if you are unable to keep a scheduled appointment to avoid a \$45.00 missed appointment or short notice cancellation fee. Missed or broken appointments for Saturdays will be charged a \$65.00 fee.

I have read and understand this policy.

H Signed: _____ Date: _____
Patient or guardian

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand 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 *Notices 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 *Notices of Private 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: _____
H Signature: _____
Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: