Acknowledgment of Receipt of Notice of Privacy Practices

I (print name of patient) _____, acknowledge and agree that I have received a copy of The Oklahoma Center for Implants and Periodontics Notice of Privacy Practice.

_____ _____
Signature of Patient or Legal Representative Date

PERMISSION TO DISCLOSURE OF PROTECTED HEALTH INFORMATION

I (print name of patient) _____, **give my permission** for Dr. Chris Poore **to give information to the people listed below** about my dental care. This information may include lab results, medications being taken, appointment times, changes in appointments, x-ray results, doctor or assistant reports about me and any other information that this office has about me.

_____ _____
Relationship

_____ _____
Relationship

_____ _____
Signature of Patient or Legal Representative Date

Financial & Insurance Agreement

Financial: We request that the fees be paid in full at the time of treatment. We accept cash, checks, money orders, Visa, MasterCard, Discover and American Express. We also accept Care Credit.
We do require new patients to pay their initial exam/x-ray fees in full at the time of service to establish their accounts.
Minors (*under 18*) will need to be accompanied by a parent, guardian or legal representative.
If an account balance should fall 90 days overdue, the balance will accrue a 1.5% monthly interest charge.
If a check is returned by your bank, a $25.00 fee will be charged to your account.

Insurance: If we are contracted with your insurance company (***In Network***) then we request that you pay your *co-insurance estimate of 20%* at the time of your visit in lieu of a predetermination. A co-insurance is the amount that insurance does not pay based on your specific plan benefits. We will gladly file your insurance claim and **you will be responsible for any balance after your insurance pays**.
If we are not contracted with your insurance company (***Out of Network***) then **you will be responsible for the total cost due the day of treatment**. We will then file your claim for you and your insurance company will reimburse you directly, usually within a few weeks.
By signing below you acknowledge that you understand and will abide by this agreement.

_____ _____
Signature of Patient or Legal Representative Witness Date