Peace Dental, P.C.

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1509 Mount Royal Blvd. • Glenshaw, PA 15116-2207

(412)486-5155

Patient Name: ______________ Last ______________ First MI ______________ Preferred Name

CONSENT FOR SERVICES AND FINANCIAL POLICY

Thank you for choosing Peace Dental to serve your dental needs. Our office is dedicated to providing the highest quality of dental care possible for every patient. The following is a statement of our financial policy. Please read it and let us know if you have any questions.

*********ALL ESTIMATED FEES ARE DUE AT THE TIME OF SERVICE**

NON-INSURED PATIENTS

0 I understand that I DO NOT have insurance coverage and select to be self pay. Payment is due on the day that dental procedures are performed. For your convenience we accept cash, personal checks, money orders, debit cards, all major credit cards, and Care Credit.

INSURED PATIENTS

I understand that I DO HAVE dental insurance and that Peace Dental will file my insurance as a courtesy and that there is no guarantee of coverage. Patient portions are an ESTIMATE and not a guarantee of exact payment. The patient is responsible for the estimated portion of the procedures and deductibles at the time of service. Once your insurance company has paid, you will be responsible for any balance that is remaining. If your insurance policy pays you directly, you are responsible for the amount they pay and your portion.

0 I understand that my insurance is OUT OF NETWORK with my chosen provider. Procedures are quoted at standard fees and I am provided with an estimate of my out of pocket according to my insurance policy. This is not a guarantee of benefits and I accept responsibility for payment of services.

0 I understand that my insurance is IN NETWORK but the benefits may not cover all services according to the estimate given. I am responsible for any deductible and patient portion at the time services are rendered and any balance after my insurance has paid.

NO SHOWS/SAME DAY CANCELLATIONS

Patient understands that appointment times are limited and therefore a 24 hour notice of cancellation prior to appointment is required.

*A $25 fee will be charged for same day hygiene appointment cancellations

*A $50 fee will be charged for same day procedure appointment cancellations

I have read, understand, and agree to all of the above. I have been given the opportunity to ask questions. If I have insurance, I hereby authorize my insurance company to pay my dental benefits directly to Peace Dental, PC and I authorize Peace Dental, PC to release any medical information to my insurance as needed to
process my claim(s).

By checking this box, I understand the above information and agree with its contents and this will serve as my electronic signature
Consent for Services and Financial Policy.

HIPAA ACKNOWLEDGEMENT

I understand that I may inspect or copy the health information described by this authorization.

I understand that at any time this authorization may be revoked. If this office receives a written revocation, the authorization will not be valid for previously released records or other actions for any prior authorizations signed.

I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this aurthorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

❑ *By checking this box, I understand the above information and agree with its contents and this will serve as my electronic signature
for the HIPAA Disclosure Form.

CONSENT FOR INTERNET COMMUNICATIONS

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical
information) to the secured website for the dental practice. I understand that for security purposes the site requires a user id and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any id and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my id and password, my disclosure of my id and password, or my authorization to allow another person or entity to access and use the dental practice website with my id and password. I also agree to immediately to notify the dental practice of any unaauthorized use of my id or of any other need to deactivate my id due to security concerns.

I also understand that state and federal laws, as well as ethical licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with the operations of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOTAND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED,
MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

- [ ] * **I have read the information above regarding the secured uploading of patient information to the website for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.**

Name of patient, parent, or guardian completing this form: ______________________________

Relationship to patient: * ______________________________

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Response Date: ______________