Delmar Dental Medicine
344 Delaware Avenue
Delmar, NY 12054
518-439-4228

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, ____, have received a copy of this
Please Print Name
office's Notice of Privacy Practices.

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Signature

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Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

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NEW PATIENT BILLING /INSURANCE/ APPOINTMENT INFORMATION

This will acknowledge that you understand you are responsible for any expenses you incur at Delmar Dental, PC. We reserve the right to bill you for failed or cancelled appointments if 24 hours notice is not given.

The failed appointment fee is $35 for a dental hygiene visit and $85 for an appointment with the Doctor.

In case of default, if the account is referred to an attorney for collection, the undersigned agrees to pay all additional charges and interest fees related to the original bill & any collection costs including attorney fees.

(Patient Signature)______________________________________ Date____________

(Responsible Party Signature)-if patient is a minor

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FOR PATIENTS WITH INSURANCE

Please remember that insurance may reimburse us for a portion of your visits with Delmar Dental Medicine. What your insurance company ultimately covers will depend upon your contract with the insurance company. We do not participate with any insurance company and it is your responsibility to pay any amount that is not paid by your insurance company..

We expect payment on the date of service for any amount that we estimate your insurance company will not cover. THIS AMOUNT IS AN ESTIMATE ONLY and once we receive a payment from your insurance company you may have a remaining balance, which you will be billed for.

IF YOU HAVE GHI, BLUE SHIELD OF NORTHEASTERN NEW YORK OR DELTA DENTAL YOU WILL BE EXPECTED TO MAKE PAYMENT IN FULL ON THE DATE OF SERVICE.

To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of my patient record.

I hereby assign all dental benefits to which I am entitled, including private insurance and other health plans to : Delmar Dental Medicine 344 Delaware Ave. Delmar, NY 12054 (518)439-4228.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges that are incurred, whether or not covered by said insurance.

SIGNED_____________________DATE____________

RESPONSIBLE PARTY(for minor)__________________

I hereby authorize the office of Delmar Dental, PC to affix my name to any and all claims or documents as related to any and all dental benefits due me and my dependents through my employment with my current employer at the time of service. I authorize payment of all dental benefits otherwise payable by me, directly to the office of Delmar Dental, PC. This "signature on file" will be valid from the date signed until such time that I am no longer a patient at Delmar Dental, PC. I understand that I am responsible for all dental services performed, and Delmar Dental, PC may accept assignment of benefits from my insurance company. Any payment made by my dental plan in most cases will be partial payment of my bill with Delmar Dental, PC. To the extent permitted under applicable law, I authorize release of any information relating to my dental claims.