Hatfield Dental Clinic,P.C.

NO SHOW POLICY

Patient Name: _____
Last First MI

It is the policy of Hatfield Dental Clinic, P.C. to optimize the use of clinic time by working to ensure that scheduled time blocks are filled by scheduled patients. Patients who do not provide the clinic with at least one business day notice of cancellation will be charged a $35.00 "No-Show" fee for missing a confirmed appointment. This charge will be collected at the next visit.

Hatfield Dental Clinic, P.C. physicians reserve the right to discontinue patient care when an established patient misses three (3) confirmed appointments without providing one business day notice of cancellation. Established patients will be notified in writing that a third missed appointment will result in termination of the physician/patient relationship. When a new patient misses two (2) confirmed appointments, that patient will not be rescheduled. Thank you for your cooperation.

Patient Signature:  _____ Date: _____

FINANCIAL POLICY

Thank you for choosing Hatfield Dental Clinic, P.C. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

You can choose from: Cash, Check, Visa, Mastercard, Discover, American Express or Care Credit.

Please note: Hatfield Dental Clinic, P.C. requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance, we are happy to work with your primary carrier to maximize your benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

All accounts 90 days past due will be referred to an outside collection agency.

Hatfield Dental Clinic charges $25.00 for returned checks.

Patient Signature:  _____ Date: _____

Hatfield Dental Clinic, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Last First MI

I have reviewed Hatfield Dental Clinic's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to and have received a copy of this document.

Patient Signature:  _____ Date: _____

Hatfield Dental Clinic, P.C.

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____

Last First MI

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Information for treatment purposes.
2. To your insurance company (if applicable), pharmacist and to doctors to whom we refer.
3. To obtain payment from your insurance, to submit a prescription, and for sharing our diagnosis and information to doctors whom you are referred.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH HISTORY INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature:  _____ Date: _____