650ACKNOWLEDGMENT OF PRIVACY

Name of Practice: Mountain West Family Dentistry

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Name of Patient (please print) **Date of Birth**

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received the Notice of Privacy Practices.

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Signature of Patient or Patient Representative **Date**

ACKNOWLEDGMENT OF FINANCIAL AND CANCELLATION POLICY

We are committed to providing excellent care for our patients. We typically schedule more time than most dental offices for dental appointments. It can be difficult to reschedule appointments when we have little notice. We request that you give us at least **48 hours** notice if you must reschedule your appointment. There may be a **$75 fee** for appointments missed with less than **48 hours notice or no communication.**

Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time.

Our office will make an attempt to appeal any claim that we feel is incorrect. We will provide the necessary documentation your insurance company requests to settle the claim. **If your insurance company has not made payment within 30 days of billing, the balance will become your responsibility.**

Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.

We are more than happy to help with your insurance, but ultimately it is your responsibility to be familiar with your plan and benefits.

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Signature of Patient or Patient Representative **Date**