ACKNOWLEDGEMENT & CONSENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES
**YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

Existing Michigan Law requires (in addition to our attempt to obtain your written
acknowledgement, discussed above) us to first obtain you written consent prior to disclosing any of
your information except for our disclosures in connection with: a defense to a claim challenging our
professional competence; a review entity's functions; a claim for payment of fees; a third party
payer's examination of our records; a court order as part of a criminal investigation; an identification
of a dead body; a licensure investigation; or a child abuse/neglect investigation.

I, (Patients' Name) ____________________________________________, have been offered a copy of and
understand the scope of this office's Notice of Privacy Practices. I consent my information, which
you deem necessary in connection with my treatment. I understand that such disclosures may not be
of the type listed above.

Patient Signature ____________________________________________             Date ___________________

INSURANCE AND FINANCIAL RESPONSIBILITY

I am responsible for the payment of the treatment that I receive at each visit. If I have dental
insurance I will disclose all necessary information and I will be responsible for any balance(s) that
will remain from my insurance. It should be understood, that the dental insurance contract is
between the insurance company and the patient, whom bears the ultimate financial responsibility.

X ____________________________ Date ___________________

FOR OFFICE USE ONLY:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify) ________________________________
Livonia Dental Care's
Office Policies and Financial Agreement

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for that oral health along with providing each patient with the highest quality of dental care. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

Regarding Insurance
For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to deal with insurance companies. There are constant changes being made by your employer and insurance carries to your coverage, deductibles and maximum. These changes do not get shared with us. Therefore, it is impossible for us to know exactly what your policy covers. It is your responsibility as a patient to know what your benefits, deductibles and maximum are throughout your policy year so that you may make informed decisions on any appointments made.

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your insurance balance for longer the 90 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. Please be prepared to show your insurance card at the time of your visit.

Payment Options
Your options include Cash, Check, MasterCard, Visa, Discover and American Express. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through CareCredit, our financial partner. If you would like to use CareCredit to assist you with your treatment needs please see the front desk for more information.

Additional Charges
A fee of $45.00 will be charged on all returned checks.

Delinquent Accounts
After 90 days, all accounts that are not paid in full may be sent to a third party collection agency.

Cancellation Policy
If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two-business days notice. All changes in your scheduled appointment must be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient.

I have read, understand and agree to the above Office Policies and Financial Agreement.

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Patient Signature Date
( Parent/Guarantor signature if patient is a MINOR)

Child's Name

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