HUDSON ENDODONTICS, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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

_____
Signature & 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 _____

Statement of Financial Policy & Dental Claim(s) Authorization

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

Payments and co-payments for services are due at the time services are rendered. We will submit a claim to your insurance company on your behalf the same day. We accept Cash, Checks, Master Card, Visa, and Care Credit.

*****Returned checks will be subject to a charge of $25.00*****

We will gladly answer any questions relating to your insurance, however, please be aware that:

1. Your insurance is a contract between you, your employer, and the insurance company. HUDSON ENDODONTICS is NOT a party to that contract.
2. We are only a North East Delta provider; however, our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies select certain services they will not cover and you will be responsible for these fees.

We must emphasize that as a dental provider, our relationship is with you, and not your insurance company. While the filing of insurance claim forms is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Please Fill out the following regarding your insurance:

Primary Insurance Company: _____ Primary Inured Name: _____

Secondary Insurance Company: _____ Secondary Insured Name: _____

We file claims electronically and by signing below you are authorizing Hudson Endodontics to file on your behalf and for your insurance company to pay Hudson Endodontics. You are agreeing that you have read and understand Hudson Endodontics financial policies.

_____
Signature & Date