



PIKE DENTISTRY

Cosmetic & General Dentistry

FINANCIAL & HIPAA INFORMATION

- Insurance is a contract between the policy holder (patient) and the Insurance Company. I understand and take responsibility for full payment on my accounts if the balance is not paid within 30 days.

I hereby authorize Pike Dentistry Office of Mark W. Pike D.M.D., P.A. to submit claims and assign benefits, on my behalf, to my Insurance Company(s) listed.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

(Driver's License # is required) _____

Do NOT release my information to the following people: _____

Your appointment is reserved especially for you. Without a 48-hour notification to cancel, there will be a fee to reschedule missed appointments.

I acknowledge the two pages of information and guarantee with this form were completed correctly and to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.

HIPAA DISCLAIMER:

- The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This Federal Law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. Without specific written authorization, we are permitted to use and disclose your health care records/information including appointment reminders with date/time of appointment, for the purposes of treatment, payment and health care operations.

- **I DO _____ I DO NOT _____ wish to have additional information about my rights under HIPAA.**

- We require payment in full for all services rendered either before or at time of visit. If account is not paid within 30 days of the date of service, you will be responsible for legal fees, collection fees, interest or other expenses incurred in collecting your account.

- YES _____ NO _____ I would like information on INTEREST-FREE THIRD PARTY FINANCING OPTIONS.

SIGNATURE _____ **DATE** _____

Please check who is financially responsible for this account: ___ Adult Patient ___ Parent or Guardian ___ Spouse