

HIPPA Privacy Practices

I have received and/or read either a paper or electronic copy of the HIPPA Notices of Privacy Practices from O'Brien Smiles. I understand that I am entitled to a copy if requested.

_____ **Initials**

Permission to Discuss Treatment and/or Billing Information

I give permission to discuss any and all health, treatment, or billing information with:

Name

Relationship to Patient

_____ **Initials**

Appointment Reminders

We will remind you of upcoming appointments by using text and email messages. Please make sure we have your current cell phone number and email address:

Email address

Cell phone

Financial / Insurance Policy

Payment is due at the time service is rendered. Our office accepts Cash, Check, Major Credit Cards, and Care Credit.

As a courtesy to our patients with Dental Insurance, we will gladly submit your claim. It is the patient's responsibility to know your dental benefits. Your Dental Insurance is a contract between you and your insurance company. We allow **45 days** from the date the claim was filed for the insurance company to pay on your claim. In the event that payment has not been received, you are responsible for the full amount of services rendered.

_____ **Initials**

Scheduling Policy

A **48 hours** notice is required to make any changes in the Doctor or Hygiene schedule. Any changes in the schedule made without proper notification will result in a cancellation fee of **\$75.00 per hour reserved**.

_____ **Initials**

I acknowledge that I have read, understand, and accept the above office policies.

Name

Date



ALLISON O'BRIEN
DMD

Dental Services of Sarasota/Lakewood Ranch

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