Health Info and Payment Policy

American Dental, PC may disclose health information such as, but not limited to, appointment time(s) and treatment, to family member(s), friend(s) or to whomever you request. But only if you agree that we may do so. Please list the individual(s) below who you authorize us to share your health information with.

(Name) (Relationship)

(Name) (Relationship)

Patient's Signature or Legal Guardian
(Type in name if submitting electronically.)

Date

Payment Policy

We will gladly process your insurance claim(s) for you and estimate your portion that is not covered by insurance. Any amount that is not covered by insurance is due at the time of service. If you do no have insurance full payment is due at time of service. Our estimates are subject to final approval by your insurance company and could change even after treatment has been completed. Cash paying discounts, if applicable, only apply when payment is made the same day as service. Any payment made after day of service will not receive any discount. By signing at the bottom you agree to the above and to the following:

1. **Cash, Check, Visa, Master Card, and are acceptable methods of payment.**
2. **A $50.00 No-Show fee will be charged for any appointment canceled without at least 24 hours notice.**
3. **A $25.00 charge will be billed to patient for any check returned to bank for any reason.**
4. **Finance charge(s) of up to 18% APR will be applied on all balances over 90 days past due.**

I have been offered a copy of Receipt of Privacy Practice

Patient's Signature or Legal Guardian
(Type in name if submitting electronically.)

Print Name

Date

Parent/Legal Guardian Signature
(Type in name if submitting electronically.)

Print Name

Date

For Electronic Submission: I do hereby acknowledge that this transaction is being conducted by electronic means and by typing my name herein below or transmitting this document to American Dental, I am subscribing to this agreement and thereby providing my electronic signature. By typing my name in the space below or by the act of transmitting this document to American Dental, I intend to be bound by the terms and conditions of the doctor-patient agreement herein and the terms and conditions therein are in full force and effect and legally enforceable against me.