SMILE RESTORATIONS

RYAN M. JOUETT, D.D.S.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

Your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health and information is available to me to read. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name/Signature: _____

Parent/Guardian Signature: _____

Date: _____ Social Security Number: _____

Address: _____ City: _____ State/Zip: _____

Telephone: _____ Email: _____

FINANCIAL AGREEMENT

As a courtesy, my insurance company will be billed on my behalf. I agree that all fees for service are payable by the insurance company to Ryan M. Jouett, DDS. My dental insurance is a contract between myself and said insurance company and not a responsibility of the practice. I understand that regardless of any dental insurance, I am responsible for my dental fees. I also understand the **responsibility for payment** of dental services provided in this office for myself or my dependents is **due and payable at the time services are rendered** unless financial arrangements have been made.
Since my time slot is reserved, I understand that a **$40 fee** will be assessed to my account for a missed appointment. A **24 hour notice** is required to **cancel** an appointment, however, if I am unable to give this notice, I understand that I will be assessed the **$40 fee.** Continued missed appointments will result in loss of future appointment privileges. Further, I will be responsible for all court costs, collection fees, and attorney's fees in the event of non-payment.
Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient a minor): _____

Witness: _____

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