



**ACCOUNT POLICY, ASSIGNMENT OF INSURANCE BENEFITS & FINANCE CHARGES**

The responsible party named on this form is responsible for the full cost of all dental services. Payment is due in full at the time services are rendered.

This office accepts assignment of insurance benefits. However the undersigned is aware that he or she is completely responsible for all charges incurred, including any shortfalls in insurance coverage.

At each visit the undersigned will pay the estimated co-payment for services rendered that day. As a free service this office will file the initial insurance claim or each visit. If ultimately the insurance company declines payment, or pays less than the estimated or expected benefit, the balance immediately becomes the patient or responsible party's responsibility and is due and payable within 45 days of that date.

All subsequent correspondence with the insurance company is the responsibility of the undersigned after the office's initial free insurance filing. If the undersigned requests that this office research and/or refile a disputed claim, the undersigned will pay twenty five dollars in advance for each claim so handled.

Any patient balance outstanding after forty five days must be paid in full before any further treatment can be rendered, or before any further assistance can be provided by this office on behalf of the undersigned as outlined above.

The undersigned hereby authorizes payment directly to the dentist of the group insurance benefits otherwise payable to the patient.

Finance charges will be charged on any outstanding patient balances after forty five days. The finance charge is 1.5% per month (annual percentage rate 18%).

I, the undersigned (patient or legal responsible party) authorize treatment to be rendered and have read, understood, and accepted the office policies described above regarding accounts, assignment of insurance benefits, and finance charges.

Signature of responsible party \_\_\_\_\_ Date \_\_\_\_\_

Witness (Staff) \_\_\_\_\_

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your or the patient's protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our [Notice of Privacy Practices](#) before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Pat Cassidy  
Telephone: (919) 596-7447  
E-mail: drpassidy@net32.com  
Fax: (919) 596-0910  
Address: 2615 S. Miami Blvd., Durham, NC 27703

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**