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.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 to obtain a current copy of the Notice of Private 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 abide by such restrictions.

Patient Name: _____

Date: _____

If other than patient filled out form-Relationship to Patient: _____

I will allow the following person(s) to have access to my records: (Example Husband, wife, child)

Print Name(s):

INSURANCE AUTHORIZATION-SIGNATURE ON FILE\e\C(If You have insurance and want us to file)\c\n
____I authorize use of a copy of this form on my insurance submissions.
____I authorize release of information to my insurance carriers.
____I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
____I authorize payment directly to my doctor.

PAYMENT POLICY

1) Total payment of fees is required at the time of treatment unless arrangements are approved in advance.
2) We accept VISA, MC, Checks, Cash and CareCredit(W.A.C)
3) As a courtesy, we can assist you in filing insurance claims.
4) 18% interest per year will be charged on past due accounts.

CONSENT & MISSED APPOINTMENT INFORMATION

1. To the best of my knowledge all of the answers on the medical history and insurance are true and correct.
2. I grant authority to Dr. Shadid to perform dental treatment that may be deemed necessary, as agreed by me before treatment.
3. As a courtesy we will send you reminders of your scheduled appointment, but, your appointment is your confirmation.
4. A Broken Appointment Fee will be charged for missed or canceled scheduled appointments without 24-48 hour notice(with some exceptions).

AUTHORIZED SIGNATURE_____DATE:_____