

the insurance company is using that price schedule. For our Non Insured patients, the fees on the pre-treatment are guaranteed up to 90 days from the diagnosing appointment.

DELINQUENT ACCOUNTS

After reasonable time and effort between Princeton Family Dental and the responsible party to collect money owed, we may deem it necessary to turn said account to an outside source for payment. If this account is assigned to any agency, attorney/law suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

NOTICE OF PRIVACY PRACTICES (HIPAA)

There is an attached copy of the Notice of Privacy Practices (HIPPA) on the clipboard. This notice provides in detail the uses and disclosures of your protected health information, your individual rights, how to exercise said rights, and this practice's legal duties with respect to your information. Princeton Family Dental reserves the right to change the terms of the Notice of Privacy Practices. **By signing below, you are noting that you understand said HIPPA policies.** Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

CONSENT OF ASSIGNMENT

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of patient's records.

I hereby assign all medical/dental/surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to:

Princeton Family Dental
275 Princeton Drive Suite #100
Princeton, TX 75407

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges (whether or not paid by said insurance). I hereby authorize said assignee to release all information necessary to secure the payment.

Please let us know if you have any questions or concerns about our policies. Your signature is acknowledging you have read and understand said policies on both of these pages.

Signature of Patient or Responsible Party

Date