APPLE DENTAL GROUP

CONOCIMIENTO DE LA LEY DE PRIVACIDAD

Yo, ____ he recibido una

explicacion de la Ley de la Privacidad.

___________________________________ ____________________

Firma Fecha

Uso de la oficina solamente

Tratamos de optener conocimiento por escrito del individuo antes mencionado de la Ley de Privacidad, pero no pudo ser possible porque:

- Una barrera comunicativa nos impidio obtener conocimiento.
- El individuo se reuso a firmar.
- Otro ______________________________

APPLE DENTAL GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ have received an

Explanation of the Notice of Privacy.

_______________________________________ __________________

Signature Date

Please note: It is your right to refuse to sign this acknowledgment.

Office use only

We tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy, but it could not be obtained because:

- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.
- Other_________________________.

Patients Financial Responsibility & Assignment of Insurance Benefits

1. My insurance policy is an agreement between my insurance company and myself.

2. It is my responsibility to understand the benefits available to me through my insurance policy. The office of **Apple Dental Group** will from time to time contact my insurance company to inquire what benefits are available through my insurance plan. The office will make its best efforts to answer any questions about my benefits but this is not a guarantee that my insurance company will actually pay for these services.

3. I understand that my insurance company does not certify or guarantee payment of any benefits until a claim is filed. Whether the office or I obtain information about benefits, this is not a guarantee of payment. The office will advise me what benefits my insurance company has verbally advised them are available to me. I realize that the choice to receive dental services is entirely up to me. By providing these services to me the office is not accepting responsibility for their cost if the services are not covered by my policy. I understand that the office, by accepting this assignment of insurance benefits will work diligently on my behalf to collect all benefits that are available through my policy. I agree to pay for services provided at my request or recommended by the office that my policy does not pay for.

4. In the event my account should become seriously delinquent, I acknowledge that the office uses a collection agency to pursue delinquent accounts. I agree to be liable for any cost associated with the collection of my account if delinquent.

I have read the foregoing and understand my obligations as outlined in this document. I have spoken with the office staff regarding any uncertainties I have and hereby request Apple Dental Group to continue my dental care. I hereby assign all benefits payable under my insurance plan to Apple Dental Group.

Assignment of Benefits & Release of Related Dental Records

I hereby assign, transfer, and set over to Apple Dental Group all of my rights, title, and interest to my dental reimbursement benefits under my insurance policy. I authorize the release of my dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Credit Card Required on File: Visa___ MasterCard___ Amex___ Discover____

Account Number:___________________ Expiration date ____/___Zip Code_____

____ ________________________

Signature **Date**