FAMILY DENTISTRY

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I acknowledge my financial responsibility to pay for all services received from Jorg Family Dentistry, regardless of insurance coverage or eligibility and that **payment is due at the time of services rendered** unless other arrangements have been made.

Initial _____

I understand that Jorg Family Dentistry will bill my insurance based on the information I provide and any unpaid charges will be my responsibility. This responsibility includes any charges not paid by my insurance carrier, including charges deemed a "non-covered benefit." If insurance cannot be verified at the time of my appointment, I will pay for the visit in full. Jorg Family Dentistry is currently a *Premier Provider* with Delta Dental and a *PPO Provider* with Cigna Dental. We are not contracted with any other insurance plans at this time.

Initial _____

I authorize release of any medical information necessary to process my insurance claim(s) and assign Jorg Family Dentistry all payment from my insurance provider(s) for services rendered.

Initial _____

I understand that while courtesy confirmations may be offered, I alone am responsible for scheduling, keeping track of and maintaining my dental appointments. I understand that appointments cancelled or changed with *less* than 2 business days' notice will be subject to a **$95** charge.

Initial _____

If the patient listed on this form is a minor, I confirm that I am financially responsible for services provided to the patient.

Print Patient Name: _____ **Initial** _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or been offered a copy of *Jorg Family Dentistry*'s Notice of Privacy Practices.

Initial _____

I hereby authorize Jorg Family Dentistry to discuss my protected health information including appointment, billing and treatment information with:

_____ _____

Name **Relationship**

My signature indicates I have read and agree to the contents above:

Print Patient Name: _____ **Date of Consent:** _____

Patient Signature: _____ **Relationship (if not patient):** _____