APPOINTMENTS

Appointments are carefully scheduled so you will be best served. Please be on time so that we can give you the attention you deserve. If you must reschedule, please allow 24 hours advance notice to reschedule an appointment. **A cancelation fee of $50 will be applied to your account for any appointment not canceled or rescheduled within 24 hours of the appointment, per patient, per appointment. We reserve the right to dismiss patients from our practice after three missed appointments.** As a courtesy to our patients, we will give a variety of appointment reminders. Some of those reminders may include, but are not limited to, appointment post-cards sent through the mail, messages left with roommates/family members, voicemail and text messages or email. Reminders contain a certain amount of specific and detail information, consisting of the patient's appointment time and date, or need for an appointment.

I authorize the office of NorthStar Dental and its staff to confirm my appointments and remind me of the need for an appointment in the above mentioned ways, for the duration of the treatment in this office.

FINANCIAL INFORMATION

All accounts are due and payable at the time services are rendered unless other prior arrangements have been made. Our bookkeeping policy prevents us from carrying balances, unless the balance is insurance related. We will send your claims to any insurance carrier upon verification of coverage regardless of our participation with them**. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I certify that I, and/or my dependent(s), have insurance coverage, and assign directly to NorthStar Dental all insurance benefits, if any, otherwise payable to me for services rendered.** We accept **Cash, Check, Visa, MasterCard, Discover and American Express.** We also offer convenient financing through CareCredit which can offer payments plans with approval of credit.

In the event a personal check is returned to our office for any reason, there will be an additional charge of $25.00 posted on your account.

NOTICE OF PRIVACY PRACTICES / ACKKNOWLEDGEMENT

We keep a record of the health care services we provide for you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us. Our **Notice of Private Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. **I acknowledge receipt of the Notice of Private Practices.**

Added Disclosure-I authorize the following person(s) to have access to all health & financial information.

Relationship:_____ Name _____

_____

Print Patient Name

_____ _____

Patient Signature/Parent or Guardian (if patient is a minor) **Date**