

Medications:

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Y N

Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

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Notes:

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Signature: _____

Date: _____

(If Under 18, Parent or Guardian Signature Required)



Dental Center
of Deerwood
Andrew Zerbinopoulos, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please specify)
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7899 Baymeadows Way, Suite 3
Jacksonville, FL 32256
(904) 731-5200

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to any treatment.

- Full payment of your estimated portion after insurance is due at the time of service
- We accept cash, checks, or Visa/MasterCard
- We offer financing through Care Credit (Credit approval required)

Regarding Insurance

WE WILL FILE YOUR INSURANCE AS A COURTESY TO YOU. THE BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. We cannot bill your insurance company unless you give us your insurance information with a valid address and a phone number. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically become your responsibility and should be paid within the following 30 days. If the balance is not paid within the 30 days, a finance charge of 18% APR will be applied to your account until it is paid. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary. All co-pays and deductibles are due prior to treatment.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult and Minor Patients

Adult patients are responsible for their financial obligation at the time of treatment. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of treatment. For unaccompanied minors, prior financial arrangements should be made with a parent or legal guardian before treatment.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge \$ 25 for missed appointments. **PLEASE HELP US SERVE YOU BETTER BY KEEPING SCHEDULED APPOINTMENTS.**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy, and I understand and agree to this Financial Policy.

X _____
Signature of Patient or Responsible Party

Date _____