

David Roach, DDS
3817 Bedford Ave. Suite 130
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Phone: 615-383-7801
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FINANCIAL AGREEMENT

Payment of your insurance specified co-payment is due at the time of service. You are contracted with your insurance company to pay this co-payment amount. Any amount insurance does not cover is the responsibility of the insured.

I, _____, choose the following option for my dental care and for the care of my dependents, if any.

Please initial one of the following:

_____ I do not have dental insurance.

- A. I elect to pay cash _____, check _____, credit card _____ at each appointment as treatment progresses.
- B. I prefer to secure a bank or credit union loan for the entire amount and make monthly payments to my lending institution.
- C. I wish to apply for your in-office finance plan. I understand that on approved credit, I may finance my entire treatment and make monthly payments.
- D. For treatment over \$400.00, I elect to pay half on the preparation date and the balance on the second appointment.

_____ I have Dental Insurance through _____;
I elect to pay my deductible and any uninsured portions as treatment progresses.

Patient: _____ Date: _____

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my information can and will be used to:

- A. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- B. Obtain payment from third-party payers.**
- C. Conduct normal healthcare operations such as quality assessments and physicians certifications.**

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you've taken action relying on this consent.

Patient Name:_____ Date:_____

Signature of Responsible Party: _____

Relationship to Patient:_____