Bandon S. Lee, DMD

PATIENT AGREEMENT

- I authorize Brandon S Lee, DMD to verify and release any medical or dental information to process my insurance claims.
- I agree to inform Brandon S Lee, DMD of any changes to my home address, phone number or insurance coverage.
- **I UNDERSTAND THAT I AM FULLY RESPONSIBLE TO GIVE THE MOST ACCURATE INFORMATION REGARDING MY INSURANCE, MEDICAL OR DENTAL STATUS. BY SIGNING BELOW, I AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO THE DENTIST BY MY INSURANCE COMPANY AND I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL SERVICE NOT COVERED. _____ (Initial)**
- Patient co-pays are due at the time of service either by cash, check (with check guarantee), Visa or Mastercard. As a courtesy to our patients we will be happy to bill your insurance company and any over-payment will be refunded to you. For those who are not familiar with your dental plan benefits, please obtain a manual from your employer's human resources department.
- After each dental visit we will provide a walk out statement that will inform you of treatment costs, co-pays and an estimate of remaining calendar year benefits. After 30 days a 1.5% finance charge will be applied along with a $5.00 billing charge for the unpaid account balance. Returned checks will result in a $25.00 charge. A cash payment in the amount of the NSF check plus the return check fee will be due within 2 business days.
- WE UNDERSTAND THAT CERTAIN CHANGES TO YOUR SCHEDULE ARE SOMETIMES UNAVOIDABLE. IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, PLEASE CALL US A MINIMUM OF **48** HOURS IN ADVANCE. WITHOUT ADVANCED NOTICE, YOU MAY BE CHARGED **$50.00** FOR A MISSED APPOINTMENT.
- We are committed to providing professional and quality care to each and every patient. To insure this standard of care, please avoid the use of cellular phones in the office. Also, to protect the privacy of our patients, family members and friends are to remain in the reception area.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payors for my health care services.

I have been informed of my dental provider's Notice of Privacy of Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and I may contact this office to obtain a current copy of the Notice of Privacy Practices.

- I authorize Brandon S Lee, DMD and/or staff to leave a message regarding my dental appointment on my answering machine and/or with (Print Name and Relationship):
- _____

Please let us know if you have any questions or concerns. Thank you.

Patient Name: _____ Date:_____

Patient Signature: _____