GRUENE FAMILY DENTAL
KIM TURNBOW, D.D.S.

**Welcome!** Thank you for choosing Gruene Family Dental, listed below are some of the office policies**. Please read and sign this form PRIOR TO YOUR APPOINTMENT**. Please let us know if you have any questions or concerns. Thanks again, see you soon.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

## INSURANCE ESTIMATES AND BILLING

Estimates for dental treatment are valid for 30 days. Payment is due at time of treatment unless other arrangements have been made PRIOR TO YOUR APPOINTMENT. For patients with insurance plans, **we cannot guarantee your coverage, we will provide an estimate**. The patient is responsible for any charges not covered by insurance. We reserve the right to charge interest in the amount of 18% per annum as provided by state law. All accounts aged past 90 days WILL BE SENT to an outside collection agency.

## RETURNED CHECK FEE

A $50.00 returned check fee will be charged for all returned checks, and no future checks will be accepted.

## SIGNATURE ON FILE

Signature on this form will allow for:

1. Processing of all insurance claims
2. Release of medical or other necessary information to insurance companies needed for the processing of your dental claims.
3. Release of information to other medical or dental providers, including laboratories, when necessary for treatment
4. Authorization for payment from insurance companies directly to Gruene Family Dental
5. Ensure payment for services rendered

I hereby authorize payment directly to the dental practice listed above of the dental benefits otherwise payable to me. I understand my signature is valid unless revoked by me. Gruene Family Dental and staff are authorized to provide any insurance company(s), claim administrator(s) and consulting healthcare professionals, information concerning healthcare advice, treatment or supplies provided. This information will be used for the purpose of evaluating or administering claims for benefits. This authorization is valid for the term of coverage of the policy or contract. I know I have the right to receive a copy of this authorization upon request.

## CANCELLATION, MISSED OR BROKEN APPOINTMENT POLICY

Appointments are confirmed with email, text and phone calls starting two weeks prior to your dedicated appointment time. However emergencies do arise and we will accommodate your schedule as best we can. If you must change your appointment we **require at least 48 hours notice to avoid any fees**.

NAME:_____ SIGNATURE: _____ DATE: _____