**CRESCENT DENTAL**
**707 Crescent Avenue,**
**Lockport, LA 70374**

I hereby voluntarily consent to dental treatment as deemed necessary by the doctors of Crescent Dental. I authorize the release of my dental/medical information necessary to process this claim.

I authorize payment of dental/medical benefits to Crescent Dental.

**HIPAA Notice of Privacy Practices**
We are required by law to maintain the privacy of you dental/medical information and to provide patients with our HIPAA Notice of Privacy Practices. This form is a notice of out legal duties and privacy practices with respect to your Public Health Information. If you have any objections of this form, please contact our HIPAA Compliance Officer.

Your signature below is only an acknowledgement that you have received a copy of the Health Insurance Portability and Accountability Act Notice Privacy Practices.

**Authorization to Disclose Protected Health Information**
By signing below, I herby authorize release of protected information to referring physicians, primary care physicians and other physicians involved in my dental/medical care. I understand that the authorizations shall remain in effect until revoked by submitting a request in writing to this office. I also understand that such use of my protected health information is not a condition for evaluation and treatment by the practice.
**Authorization to discuss your dental health with authorized family members, if deemed necessary.**

**Authorization to use Protected Health Information to Contact Me about Appointments**
I understand that it is a policy of the practice to contact patients by phone and by mail to remind them of appointments. Refusal to permit these activities will interfere with the patient of this practice. By signing below, I am authorizing this use of my protected health information by the practice.

**Billing Policy**
We may accept assignment of insurance benefits. However, we do require a percentage of the bill to be paid at the time of service along with your deductible. The balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you give us the correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide credit card authorization to bill that account for the balance. **If your insurance company has not paid your account in full within 60 days, you will be responsible for your total balance**. For your convenience, we accept personal checks, cash, money orders, major credit cards and Care Credit. **Care Credit** is a dental financing group that offers up to 12 months interest free or extended financing @ 14.9 % up to 60 months **with approved credit**. **All accounts over 90 days are subject to 18.5% finance charge**. Crescent Dental has my consent to charge any credit / debit card on file for any outstanding balance that I have due, without my signature. There will be a $40.00 per check NSF fee, if a check is returned with non-sufficient funds available. **If account is not paid within 60 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.**

**Cancellation Policy**
Because we take our patients very seriously and see them when they are scheduled, we ask that our patients extend us the same courtesy. We ask that cancellation notices be given at least 24 hours before the appointment. If you cancel your appointment in less then 24 hours or fail to show up for your dental appointment, our office charge is $30.00 per hour scheduled. We do call our patients the business day before their appointment to confirm, but this is a courtesy call and not an opportunity to cancel. The responsibly for keeping appointments lie with the patient or the patient's guardian.

Signed:_____Date_____