LAKES REGION DENTAL CARE
Ashleigh and Chandler Jones, DMD
Patient's Responsibility
Bill of Rights and Disclosure Agreement

- I agree to be on time for my appointment and I understand I may be billed for any appointments missed if I fail to notify the office 48 hours in advance.

- I understand payment is due at time of service and I agree to pay my payment/co-payment at the time of my appointment.

- If I fail to pay my bill in a satisfactory manner I realize I may not be allowed to have future office visits until the balance is paid.

- I understand that the office can only bill for a service documented in my record and ask the doctor/office to change the diagnostic code to secure insurance payment constitutes fraud.

- I will make every effort to understand the benefits of my insurance plan, even to the extent of calling the carrier or the benefits coordinator at my place of employment. I understand I am responsible for payment of services I receive, including services not covered by my insurance.

- My records will be held in strict confidence and for anything other than treatment, payment or healthcare operations, will not be released without my written notification or authorization.

- I can best be reached at home #_____office #_____
  cell #_____

- The office may _____ leave a call back number or ____leave a message.

- If you would like us to be able to discuss your treatment with another party, please state below:
  _____ DO NOT discuss treatment with anyone but me
  _____ You can discuss treatment with_____

- I understand I have been offered a Notice of Privacy Policy that provides a more complete description of protected healthcare information uses and disclosures. A revised copy of notice can be obtained in our office.

- By signing this form, I fully understand and accept the terms of this agreement.

Signed_____ Date_____

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