Watkins Family Dental

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I consent to various communication methods by Watkins Family Dental including but not necessarily limited to: phone, email, texting, and social media sites messaging systems.
- We are active partners in the Winfield High School Health Careers Program. This consists of students observing in the dental office. By signing below you are consenting to allow a student observer be present in the treatment room.
- If you have insurance, we will do our best to process your claim and estimate what insurance will cover. If you have any questions regarding your insurance, you may call your insurance company for verification of benefits. If you need assistance with this, we will be glad to provide you with any helpful information that we can.
- Patient is responsible for any amount not covered by insurance.
- Payment is expected at the time services are rendered. If you are unable to pay for the services, arrangements need to be made BEFORE your appointment.
- In the event payment is not paid within 30 days from the date the same becomes first due, the undersigned does herby agree to pay an additional 40% penalty fee.
- Our office gladly accepts Medicaid to assist with the cost of dental care for members of our community. However, due to the loss of our office incurs by accepting the limited amount Medicaid allows for procedures, we must enforce a strict policy concerning appointments.
- If you cancel or reschedule any dental appointment without giving 48 hours notice, scheduling of future appointments will be at the discretion of Watkins Family Dental.
- If you are more than 5 minutes late for your scheduled appointment, you may be asked to reschedule.
- Parents are asked to stay in the waiting room unless we request for you to come back with your child.
- At times photos may be taken during treatment. I give my permission that any records made during the process of examination, and treatment may be used for the purposes of research, education, or publication in professional media.
- I have read over and understand my patient rights as outlined by the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPPA)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE POINTS ABOVE, AND THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THE HIPPA FORM.

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Signature Date

If you have any questions regarding our policies, feel free to ask.
Thank you, Dr. Tony Watkins and Staff- Updated 4/18