# GAGE CENTER DENTAL GROUP, PA

## INFORMED CONSENT
## and
## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**1) I, _____, have received a copy of Gage Center Dental Group, PA's Notice of Privacy Practices.**

**2) To be in compliance with the Health Insurance Portability & Accountability Act (HIPAA) Federal regulations, our Notice of Privacy Practices indicates that Gage Center Dental Group, PA *may not* discuss your medical care with anyone without your expressed written permission, except in the case of an emergency or as required by law. Gage Center Dental Group, PA *may* disclose patient information to carry out treatment, payment, or health operations to referring doctors, pharmacies, insurance companies etc..**

**Please list below the full names of people with whom you give Gage Center Dental Group, PA authorization to discuss your case i.e. medical, treatment, appointments, finances etc.. Ex: spouse, parent, child, sibling, friend, interpreter.**

_____ _____

_____ _____

_____ _____

**3) Your appointment time is reserved specifically for you. Failure to keep an appointment without notifying our office 24 hours in advance may result in a missed appointment charge that is not covered by insurance. If you are more than 10 minutes late for your appointment we may need to reschedule.**

**4) Payment is due at the time of service. We pre-authorize treatment and file insurance claims as a courtesy to our patients. The patient is responsible for their portion of the costs at the time of the appointment regardless of what insurance may or may not pay.**

**5) The parent/guardian accompanying a minor to the appointment is financially responsible for the account.**

**6) 1.5% per month will be added to charges on accounts not paid within sixty days after the date of treatment. This periodic rate equals an ANNUAL PERCENTAGE RATE OF 18%. In the event of default the patient will pay all collection charges and/or attorney fees to recover unpaid balances.**

**I hereby grant permission to the staff of this office to administer such medications and anesthetics and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.**

_____ _____

**Signature** **Date**

**As a courtesy, please silence your phones once you have been called into the treatment room.**