REVIVE
SMILES DENTISTRY

259 Yale Avenue North, Seattle, Washington 98109
phone: 206.829-8565 fax: 206.739.5797
admin@revivesmilesdentistry.com

We appreciate you choosing our practice for your dental care. In order for us to provide you with optimal service, we would like you to take a moment to read our office guidelines.

Payment is expected on the day of service. Our office does not bill patients. We will accept payment by cash, check, or credit card (Visa or MasterCard.) Returned checks due to insufficient funds will result in a $25 returned check fee added to your account. We do offer a dental finance plan.

If you have insurance, we will bill the insurance company as a courtesy to you, however you are responsible for all charges incurred. We do collect your co-payment at time of service and any estimated portion. If your insurance company (primary or secondary) denies charges for any reason the financial responsibility is yours.

Minors (patients 18 years old and younger) must be accompanied by a parent or legal guardian. Unaccompanied minors will be denied treatment unless treatment and payment has been approved. Parents and legal guardians are not permitted in the operatories and are asked to wait in the reception area during treatment.

I understand that my appointment time has been especially reserved for me and that Hidden Valley Smiles confirms appointments as a courtesy only. In the event I need to reschedule an appointment I understand Hidden Valley Smiles requires 48 hours working day notice. I understand if I am unable to give 48 hours working day notice I may be charged a fee of $50 per hour. We reserve the right to not reschedule an appointment or to cancel an appointment if we are unable to contact you. I understand that if I am more than 15 minutes late for a scheduled appointment, I will not be able to be seen that day and will have to reschedule my appointment.

I authorize the dentist to perform diagnostic procedures and treatment for proper dental care. I authorize the release of any information concerning my (or my child's) dental health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I have read the office guidelines. I understand and agree to these guidelines.

Patient/Guardian Signature _____ Date _____

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I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Hidden Valley Smiles. The Statement of Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for service, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Hidden Valley Smiles reserves the right to change the privacy practices that are described in The Statement of Privacy Practices. If Privacy Practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Patient Name: _____

Date: _____

Signature: _____

Relationship to patient:

Dependent family members also covered by this acknowledgement:

_____

_____

_____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ○ The patient refused to sign
- ○ Patient unable to sign
- ○ Communication barriers
- ○ Emergency situation
- ○ Other: Explain _____