# ***Welcome to Gold Canyon Dentistry***

## Acknowledgement of Receipt of Notice of Privacy Practices

I, ___________________________ acknowledge that I received and reviewed Gold Canyon Dentistry Privacy Policy Notice.

Patient's Signature: ________________________________________ Date: ______________

## Missed Appointment Policy

Due to the high number of patients requiring dental care, waiting times for appointments can be long. Because of this, we ask that you allow 24 hours minimum for cancelled appointments, failure to do this, or "No Show" appointments will be charged a fee of $42. Thanks for your cooperation helping offer appointments in a timely manner.

Signature: __________________________________________________Date:_____________

## Financial Agreement

This office is happy to cooperate with individuals who have dental insurance. Our office will file your claims with your primary insurance carrier. Your dental insurance company is under contract with you and your employer. We ask that you read your policy and understand all limitations of your benefits. Please call your insurance agent if you have any questions. YOU ARE ultimately responsible for cost related to your care.

●The fees charged to insured individuals are our Usual and Customary Fees.

●If you do not have insurance, you will be expected to pay in full at time of service. We accept MC, Visa, Discover, Care Credit, Check, and Cash.

●We require a co-payment on the day of your dental services (Example, 80/20, 50/50) as contracted by your insurance provider.

●After insurance benefits have been paid; any unpaid balance is your responsibility. Balance after 90 days will accrue a 1.5% per month interest charge.

● If you are in default, the entire unpaid balance, and any collection fees will become immediately due and transferred to a collection agency.

●We wait 30 days for your insurance company to pay your claim. If your insurance company fails to pay or rejects your claim we require you to pay the balance in full and seek reimbursement from your insurance company. A fee will be added to your account if collections proceedings are retained.

Signature: _________________________________________________ Date: ___________________

## Request for Records

All x-rays provided by GCD and taken by GCD become office record of GCD. We will not release original records. Duplicates may be requested with written consent on file.

Signature __________________________________________________ Date: _______________