JENNIFER E. TAYLOR, DDS

Taylor Family Dentistry, LLC

In-Office Patient Form

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Patient's Name *(Please Print)*

A. **HIPAA Acknowledgement:** I have read and have been offered to receive a copy of Taylor Family Dentistry, LLC's Notice of Privacy Practices (HIPAA).

B. **HIPAA Communication:**

1. Office Policy: Confidential dental treatment information cannot be released to family members or friends, except: (a) To parents, legal guardians, or others authorized by the patient, (b) In emergency situations, or (c) To others as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, Taylor Family Dentistry, LLC realizes that you may also want/need to have your dental information released to individuals other than yourself (i.e. family members, friends, caretakers, etc.). Therefore, in order to comply with this request, please provide the information in the space below.

_____ Relationship _____

_____ Relationship _____

2. Office Communications: As a patient of Taylor Family Dentistry, LLC, you may also elect additional methods of communication, aside from phone calls and mailings.

Text Message _____ Email _____

C. **Financial Responsibility:**

I have provided this office with the correct and current insurance information.

I understand that I shall not be charged more than what my insurance authorizes.

I understand that I shall be responsible to pay all patient costs on the Day-of-Service.

I understand that I shall be responsible to pay any and all additional patient costs associated with my dental treatment as assigned by my insurance company.

I understand I may be charged a $50.^{00}$ No-Show/Late Fee, if the scheduled dental appointment is not canceled during Taylor Family Dentistry's hours of operation and at least one full business day prior to the appointment time.

D. **Signature:** I have read and acknowledge the Policies and Responsibilities contained herein.

_____ Date: _____

Legal Signature

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