***I, the undersigned, do hereby acknowledge that I have read, answered to the best of my knowledge, and understood all statements on this document:***

- We keep a record of the dental/health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.
- I acknowledge availability of a copy of the office Notice of Privacy Practices should I wish to receive one.
- My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996.
- I understand that this information will be held in the strictest of confidence and if I ever have any changes in my health or medicines, it is my responsibility to inform the office and doctor at my next appointment.
- This office offers Nitrous Oxide (Laughing gas) to our patients for a fee. Most insurance does NOT pay for this option and payment is due at time of use.
- This office accepts most insurances but this does **NOT** guarantee payment of coverage from insurance companies. Payment is due at or before time of service. To this end, I authorize the release of any medical/dental information requested by my insurance company. I authorize payment of benefits directly to Dentistry of Bellevue.
- Finance charges may be charged to balances over 60 days at the rate of 9% per annum. If my account becomes past due, I/we agree to pay all attorney fees, court costs, filing fees and process service fees which may be assessed by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in King County.
- You and /or your assignees are hereby authorized to contact me by any telephone numbers, pagers, cell phones, emails and addresses provided by me, or otherwise obtained by you, using an automatic telephone dialing system and to leave prerecorded messages on these devices.
- I hereby authorize my Providers office to administer such medication and perform such diagnostic and therapeutic procedures as may be necessary for proper medical/dental care including but not limited to x-rays, CT scans, photographs, anesthetic, etc.
- Payment is due at or before the time services are rendered.
- We realize your time is valuable and your schedule may change so it may be necessary to reschedule or cancel your appointment. Your appointment time is reserved just for you. We reserve the right to charge a minimum of $75 per hour appointment in order to cover expenses occurred during the allotted time for your appointment should you not show up or your appointment is cancelled with less than 48 hours' notice.

_____ _____

Signature of Patient or Guardian Date

Print Name:_____.