

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
EMAIL ADDRESS

**HIPAA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

\_\_\_\_\_  
INITIAL

**DENTAL MATERIALS FACT SHEET**

I have received a copy of the Dental Materials Fact Sheet as required by law.

\_\_\_\_\_  
INITIAL

**AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS**

I agree that Young Dental Group may communicate with me electronically at the email address above. I am aware that there is some level of risk that third parties may be able to read unencrypted emails. I can withdraw my consent to electronic communications at any time.

\_\_\_\_\_  
INITIAL

At Young Dental Group, our goal is to provide dental health care that exceeds the standards of our peers. We will provide this care in the most courteous, cost effective, and conscientious atmosphere. It is important that you are involved in your care. This involvement starts with a clear understanding of our office policy that **payment for dental services is due on the day services are rendered.**

**DENTAL BENEFIT PLANS:** As a **courtesy**, Young Dental Group will process insurance claims on the patient's behalf and help the patient **estimate** the covered benefit amount. **Young Dental Group is an out of network provider for all plans.** I acknowledge that any amount not paid by my benefits plan is my responsibility.

\_\_\_\_\_  
INITIAL

**CANCELLATION POLICY:** Time has been specifically reserved for my appointment. Appointments must be canceled at least **48 hours** prior to appointment or a **fee will be applied: \$65 for failed hygiene appointments, \$100 \$100 for failed doctor appointments.** Monday appointment cancellations must be made by the prior Friday by 5:00PM.

\_\_\_\_\_  
INITIAL

**FINANCIAL POLICY:** Young Dental Group has permission to bill my credit card on file for any outstanding balance on my account.

\_\_\_\_\_  
INITIAL

\_\_\_\_\_  
CREDIT CARD NUMBER

\_\_\_\_\_/\_\_\_\_\_  
MONTH YEAR

\_\_\_\_\_  
CVV CODE

\_\_\_\_\_  
BILLING ZIP

I certify that all information is complete and accurate. I authorize Young Dental Group to collect payment noted above by processing a charge to the credit card listed above. By signing below I certify that I am the authorized signer and will be responsible for all charges authorized by this form.

\_\_\_\_\_  
SIGNATURE OF PATIENT/RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF PATIENT/RESPONSIBLE PARTY

# Insurance Agreement

Please initial each area that you understand. Let us know if you do not understand any specific parts. Our team will be more than happy to assist you!

Initial the following:

- \_\_\_\_\_ **As a courtesy** to our patients, Young Dental Group will help process dental insurance claims. Most insurance companies will respond within four weeks.
  
- \_\_\_\_\_ Your dental insurance is provided to the patient through a contract between the patient's employer and the dental insurance company. **Young Dental Group is an out-of-network** for all plans.
  
- \_\_\_\_\_ Before treatment, we can provide an estimated copay based on information the patient's insurance company provides us. This is only **an estimate, not a guarantee** that the insurance company will pay exactly as estimated, as insurance plans are subject to limitations.
  
- \_\_\_\_\_ Any balance denied or unpaid by the patient's insurance company is **the patient's responsibility**.
  
- \_\_\_\_\_ If the patient's insurance pays more than the estimated amount, a refund will be given to the patient.
  
- \_\_\_\_\_ If the patient's insurance does not reimburse Young Dental Group after two attempts, the patient will be **responsible for the remainder** of the balance. We recommend that patient's contact their insurance company regarding questions or issues. Again, the insurance policy is a contract between the patient and their insurance company.

Please contact your insurance company for details on your specific policy. Our team at Young Dental Group will be more than happy to help explain your benefits or answer questions you may have about your plan.

\_\_\_\_\_  
SIGNATURE OF PATIENT/RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF PATIENT/RESPONSIBLE PARTY