

and at your request we will gladly contact your insurance company to verify eligibility of x-rays.

X-ray
refusal _____ Date _____

HIPPA PRIVACY PRACTICE ACKNOWLEDGMENT

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

ACCOUNT BALANCE RESPONSIBILTY

I am aware that as a courtesy to me, Children's Dentistry of West Cobb will file my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that if my account is 90 days past due, I will be turned over to collections in an effort to collect the remaining balance owed. The collection agency will charge me a fee to collect this outstanding balance.

GUARDIAN AUTHORIZATION

I give the following two people permission authorize treatment for my child in the event I am not able to attend a future appointment. I understand I will still be held responsible for any payments due for the treatment rendered on that day.

Relationship

Relationship

Patient's
Name

Parent/Guardian
Signature

I understand and agree to the above policies

Date