# Hilton Head Dental Team

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92 B. Main Street, Hilton Head Island, SC 29926

## ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed/received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

Patient Name (Please Print) Patient Signature Date

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Or

Print Personal Representative Name Representative Signature Date

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Authority of Personal Representative to Sign for Patient (check one):

Parent ( ) Guardian ( ) Power of Attorney ( ) Other ( )

Please Note: It is your right to refuse to sign this Acknowledgement.

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**Financial Arrangements**

For your convenience, we offer the following methods of payment. Please check the option which you prefer.
Payment is due in full at each appointment.

- Cash
- Personal Check
- Credit card ___Visa ___ Master Card ___ Discover ___ American Express ___ Care Credit
- I wish to discuss the dental office's policy.

If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

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**Dental Office Use Only**

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement.
- A communication barrier prevented us from obtaining acknowledgement.
- The individual was unwilling to sign.

Other: ______________________________________________________________________________

**Staff Member Signature** **Date**

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