Metro West Dental Specialty Group

CANCELLATION POLICY
We require a 24 hour cancellation notice. If you do not inform the office within 24 hours of your scheduled appointment, you will incur a $50.00 cancellation fee.
Initials _____

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge receipt of Metro West Dental Specialty Group's notice of Privacy Practices and Patient Rights. I have had the full opportunity to read and consider the contents of Notice of Privacy Practices. I understand that by initialing/signing this form, I am giving my consent to Metro West Dental Specialty Group's use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.
Initials _____

ASSIGNMENT OF INSURANCE BENEFITS
The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefit services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as thought the undersigned has personally signed the particular claim. I authorize payment of dental benefits to Dr. Takanari Miyamoto or Metro West Dental Specialty Group for services rendered, and further understand that if at the end of sixty(60) days from the date of filing the claim my insurance company does not respond with payment to my account, I am responsible for the full amount of charges.
I acknowledge and understand that I am responsible for all the charges and for all the services rendered to me or any member of my family.
Initials _____

PAYMENTS AND INSURANCE POLICY
Payments are due the day services are rendered. Though this office gladly assists patients in preparing the forms or reports necessary for their obtaining insurance benefits, all professional services rendered are charged directly to patients, who are personally responsible for payment of fees. After SIXTY (60) days a finance charge will be assessed on the unpaid balance.
It is the policy of this office to help patients identify benefits available under the terms of their insurance policy, but our help in filling out a claim **DOES NOT GUARANTEE PAYMENT** by the insurance company. The final Benefits payable are determined according to the insured's eligibility, the limitation and exclusions, (including pre-existing limitations) and conditions related coverage. Questions regarding your benefits should be directed to your insurance company.
ANY BALANCE REMAINING ON YOUR ACCOUNT AFTER INSURANCE PAYMENT HAS BEEN RECEIVED IS THE PATIENT'S RESPONSIBILITY.
Initials _____

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Patient or Guardian Signature	Date