Acknowledgement Of Receipt
Of
Notice Of Privacy Practices

I, ____ have received a copy of
(Name of Patient)

HELOTES COSMETIC & FAMILY DENTISTRY, PLLC's Notice of Privacy Practices.

____
(Signature of Patient/Legal Guardian) Date

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

____________ Patient refused to sign.

____________ Emergency situation kept us from obtaining the patient's signature.

____________ Language barriers kept us from obtaining the patient's signature.

____________ Other ____

Helotes Cosmetic & Family Dentistry
12800 Bandera Rd., Ste. 100
Helotes, TX 78023

Office Policies

In order for us to effectively deliver exceptional services to our patients, the following Office Policies will be strictly followed:

1. Please be punctual to all of your schedule appointments. A phone call is greatly appreciated, at least 24 hours in advance, if a scheduled appointment is needed to be rescheduled or canceled. Unless a “no show” is due to an emergency, a $25.00 charge will be posted on your account for each broken appointment.

2. Patients with more than 2 (two) consecutive “no show” may be, at our discretion, discontinued from receiving further, elective dental cares at this facility thirty (30) days from upon receiving written notice from Helotes Cosmetic & Family Dentistry.

3. All applicable co-pays, for the procedures to be done at each appointment is due, prior to be seen by the Doctor or the Hygienist, unless prior written financial arrangement has been made.

4. Submitting claims to insurance company for reimbursement is the patient’s sole responsibility. Our office will be glad to offer assistance, in any way that we can, to maximize the use of the patient’s insurance benefit. Patient is the ultimate party responsible for all balance(s) on his or her account. If patient is a minor, the parent(s) or legal guardian is responsible for his or her account balance.

5. There will be a $30.00 charge for each returned check, not honored by our and/or patient’s financial institution. All “hot checks” will be forwarded to the District Attorney Office for collection.

6. All “uncollectible balances”, over 90 days old, may be forwarded to third party collection agency for collection. Patient is solely responsible for all charges incurred during the collection process, plus any applicable Attorney/Court fees, if legal proceeding is utilized.

7. Small children, who are patients or accompanying party, should be closely supervised by the accompanying parent or legal guardian. Our office in not liable or responsible for any accidents arising from lacks of parental supervision.

8. No foods or drinks are allowed in the treatment area.

9. To avoid distraction, all electronic communication devices, such as cell phone, pager, etc… need to be turned off or put on vibration mode before entering treatment area.

____
Patient’s (or Legal Guardian’s) Signature   Date

____
Witness’/ Translator’s Signature   Print Name Here   Date

The above information is subjected to changes without advanced notice.