MOODY STREET DENTAL

509 Moody Street, Waltham, MA 02453
Phone: 781-894-0889 Fax: 781-891-6857

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ have received a copy of this office Notice of Privacy Practices.

_____ _____

Signature date

X-RAY COPY AGREEMENT

Federal regulations require that **we keep your original X-Rays** at our clinic. If you need a copy of x-rays for a Second Opinion Exam by another doctor, or for an independent medical examination please allow us at least one week to get them to you. X-Ray copies are at an additional cost to you. Only Digital X-rays can be sent by email at NO Charge.

_____ _____

Signature date

FINANCIAL AGREEMENT

Thank you for choosing Moody Street Dental as your dental health care provider. We are committed to providing the **highest quality of dental care,** and continued maintenance of your oral health.

Please understand that paying for your dental work is considered to be an integral part of your ongoing treatment. The following is a statement of our Financial Agreement, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service. We accept cash, check, credit cards, and offer extended payment plans, through independent credit companies with credit approval.

If your account is not paid with in 90 days of the date of service, and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting on your account.

Dental Insurance: all co-pays and deductibles are due on the date of the service. The balance is your responsibility, whether your insurance company pays or not. Please remember we submit bills to your insurance as courtesy to you. The price difference in mercury free restorations is your responsibility.

Minor patients; students: the adult accompanying a minor (parent or guardian) is responsible for full payment.

Missed appointments: **Unless canceled 48 hours in advance, our policy is to charge $75.00 (seventy five dollars).** If emergency situations arise that prevent you from keeping your appointment, please let us know as soon as possible, so we can reschedule your appointment.

Please help us serve you better by keeping your scheduled appointments.

I _____ authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Moody Street Dental of any changes to the information I have provided.

_____ _____

Signature date