GRANDVIEW DENTAL
ADAM MCLACHLAN DDS

Agreement for Dental Services

1. **Courtesy insurance claim.** As a courtesy we will be glad to file your claim if you provide the following: your dental insurance card and all required employer information. You will be expected to pay up front for services if the office is unable to verify your insurance information before any treatment.
2. **You are responsible to pay your entire bill.** Insurance benefits are determined by your insurance provider, not your dentist. Your insurance policy is a contract between you and your insurance company. Proof of insurance is not a guarantee of payment; insurance typically will not pay for all of your costs. Payment is due at time of service.
3. **Collections.** By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However regardless of insurance coverage, I agree that it shall remain my responsibility to pay all amounts owing as set for herein. I agree that interest will accrue on all past due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party debt collections agency, I agree that in addition to any other amounts(s) allowed by law =, (such as interest, court costs, reasonable attorneys fees, ect) I will also be responsible for collection fee of 40% of the principal amounts(s) owing as allowed by Utah code annotated, sec. 12-1-11. The terms of the paragraph shall apply to all the amounts(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.
4. **48-hour Cancellation policy.** Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise. Grandview Dental reserves the right to charge a **$50.00** fee for an appointment that is missed or cancelled without the 48-hour advance notice.

HIPAA Acknowledgement

We are committed to keeping all of your information private and will not discuss or share personal information except with those authorized by you. We shred and properly dispose of all documents that have any personal information on them. Your email is kept private. We fully comply with all provisions and HIPAA privacy practices.

I understand that I may inspect or copy the protected health information described by this authorization.

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature _____ Date _____

(Responsible party if under 18 years old)