

Dear Patient,

In an effort to present information to all of our patients as efficiently as possible, please read the enclosed policy and information statements and sign this form. A copy is available at your request.

Thank you,
Merrimack Dental Associates

FAILED APPOINTMENT POLICY

We understand that life can become hectic at times and that some appointments may need to be changed. **Please provide at least 48 hours advance notice when an appointment time needs to be changed.** Appointments that are failed without advance notification are subject to a \$40.00 failed appointment fee. Failing two or more appointments in an 18-month period may limit the ability to schedule future advance appointments.

PAYMENT POLICY

Payment of the non-insured balance for each appointment is due at the time of service. It is each patient's responsibility to know available insurance benefits. As a courtesy, we will bill your insurance carrier. Any balance remaining after insurance company processing is due immediately upon closure of each claim.

Any account that becomes delinquent and is referred to an outside collection agency will incur the collection agency's fee, in addition to the account balance.

NOTICE OF PRIVACY PRACTICES (HIPAA)

I have received and read the Merrimack Dental Associates Notice Of Privacy Practice. An additional copy is posted in the office.

N.H. BOARD OF DENTAL EXAMINERS DENTAL MATERIAL FACTS CHART

I had the opportunity to read the New Hampshire Board of Dental Materials Facts Chart. A copy is posted in the office. An additional copy is available upon request.

Patient Name (please print): _____

Patient (or guardian) signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: _____

Relationship To Patient: _____