Legacy Trails Dental
Notice of Privacy Policies

Last Name:_____ First Name:_____ Birthdate:_____

Date:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Financial Agreement

*For my convenience, this office may release my information to my insurance company and receive payment directly from them.
*I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
*If sent to collections, I agree to pay all related fees and court costs.
*Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
*I will pay a fee for appointments broken without 24 hours notice.
*Treatment plans may change, and I will be responsible for the work actually done.

I agree to the terms of the financial agreement with Legacy Trails Dental

X _____