MAGNOLIA FAMILY DENTAL
COMPREHENSIVE AND COSMETIC DENTISTRY

605 Olney-Sandy Spring Rd.
Sandy Spring, MD 20860
301-774-8555

POLICY AGREEMENT

Acknowledgement of Privacy Practices Notification

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices (HIPPA). 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 Policy

Our office expects payment at the time of service. As a courtesy, we will submit dental insurance for our patients. We will try to estimate any co-payments due from the patient on the day of the office. I authorize my insurance company to pay benefits otherwise payable to the patient, directly to Sarika Tamaskar and Reese Ruder, DDS. A patient or patient's responsible party will be responsible for all fees related to dental services rendered, insufficient funds charges and any expenses associated with collection.

I, the undersigned, understand all of the questions and policies contained in this document and have provided full and accurate answers. I will promptly inform the office of Magnolia Family Dental regarding changes in patient information and medical status.

_____ _____

Signature of Patient (or Parent, Guardian, Legal Representative) **Date**

This form was completed by (please print name) _____